The A to Z guide of your Transport Health membership

19 November 2021

Transport Health

1300 806 808
enquiries@transporthealth.com.au

While you are making your decision about whether to join Transport Health, and which cover is best for you, it is important that you read (and retain for future reference) this booklet and any other materials that we might send to you or refer you to.

The information contained in this booklet is general information about Transport Health's insurance services and products, and provides a summary of our covers. Transport Health takes care to ensure the information found in it is complete and accurate. The information does not, however, represent the complete list of cover, waiting periods and benefits in relation to Transport Health's insurance services.

Transport Health accepts no responsibility for loss or expense arising from reliance on the information found solely in this document. You should confirm any benefit, waiting period or statement within any of Transport Health's policies and obtain advice specific to your individual circumstances by contacting Transport Health on **1300 806 808**.

Effective from 19 November 2021. Fund rules and policies are subject to change without notice. If a change will adversely affect your membership and / or benefits, we will notify you in writing. Depending on the issue, this may be through a personally addressed letter, via email or other communication.

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Joining Transport Health

Residents / non-residents of Australia

Any Australian resident with full Medicare entitlements is able to join. We are unable to provide full cover to anyone who is ineligible, or only partly eligible, for Medicare.

Transferring from another health fund

Private health insurance legislation enables people to transfer between Australian health funds without having to re-serve the waiting periods they've already served with their previous fund – it's called 'portability' or 'continuity' of cover. What it means is that we'll recognise any waiting periods (or portions of waiting periods) you've already served if you join us within two calendar months of leaving your previous health fund.

When you transfer to Transport Health from another fund, the only time waiting periods apply is when your Transport Health cover offers a higher level of benefits than you had with your previous fund. In this case, you'll be entitled to the same level of benefits you had under your previous cover until you've served the waiting period for the higher level Transport Health cover.

Transferring from a cover with a higher excess to one with a lower excess (for example, from a $500 excess to a $250 excess) counts as an upgrade in your cover. In this case, you may have to pay your previous higher excess until you've served the waiting period for the new, lower level excess.

As well as recognising the time you've already spent with your previous fund, we may also take into account some of the Extras claims you've made with them when calculating your annual limits and entitlements. In some cases, within your first 12 months of membership with us, the amounts you've already claimed with your previous fund may be deducted from your annual limits until the limits refresh on 1 January each year. Where you have already claimed an amount under any 'lifetime limit' with your previous fund, this amount will be permanently deducted from any lifetime limit available under your Transport Health cover.

Overseas health funds

For the purpose of providing continuity of cover, we are not able to recognise health insurance held overseas, or any 'overseas visitor' or 'overseas student' cover provided by another Australian health fund.

If you are just starting out with health cover in Australia for the first time, or after a period of being overseas without having an Australian health cover, all waiting periods will apply.

Transfer certificates (also known as clearance certificates)

A transfer certificate is a document provided when you move from one Australian health fund to another. It contains all the information the health fund you are transferring to needs about your previous membership, including the length of your membership, your level of cover, your Lifetime Health Cover loading status and certain claims information.

When you join Transport Health, you will give authorisation for us to contact your previous fund and obtain details of your health cover with them. Under legislation, health funds are required to provide transfer certificates within 14 days of request; however, this isn't always adhered to. Delays in obtaining your transfer certificate can mean that we are unable to recognise waiting periods already served, and that we are unable to establish whether a Lifetime Health Cover loading applies to your membership. While we are waiting on your transfer certificate, your membership can be activated, but you will be unable to make claims. On occasion, if we have been unable to obtain a transfer certificate on your behalf, we may ask you to contact your previous fund to request one directly. As soon as we have received your transfer certificate we will determine whether any waiting periods apply to you. For claims arising from treatment received prior to this date, we will pay those claims to the extent covered and subject to any applicable waiting period.

If the information on the transfer certificate conflicts with the information provided by you upon joining, the certificate will take precedence. If the certificate shows that you have a Lifetime Health Cover loading that wasn't taken into consideration based on the information provided upon joining, we will add the loading to your membership and this will increase the cost of your health cover above the amount you would have originally been quoted. You'll be required to pay the additional amount before you are eligible to make any claims.

Cooling-off period

We offer a 30-day cooling-off period so that you can join, upgrade or downgrade risk free. If you change your mind within the first 30 days, and you haven't made a claim on your new cover, we'll offer you a refund. Please note, all the usual benefit waiting periods apply during the cooling-off period to the extent you have not already served them or they have been waived).

Your membership

Your membership card

When you join Transport Health, you'll receive a card that shows your membership number and lists all of the people covered. You should check this when you first receive it, and whenever you receive a replacement card, to ensure we have your name spelled correctly, and that everyone you intended to cover is listed.

Your card enables you to make on-the-spot electronic claims through HICAPS, and you'll be asked to present it if you are going to be admitted to hospital.

Your membership card is valuable as it enables anyone using it to make on-the-spot claims, so please keep it safe, and if it is lost or stolen, let us know as soon as possible so we can cancel it and issue a replacement card.

Principal member

When you complete your application, you'll be asked to nominate one person in whose name the membership will be held – this person is known as the 'principal member.' He or she is the person responsible for the membership and to whom we are responsible for communicating important information.

Specifically, the principal member is responsible for:

- ensuring that all information included in the application is true and correct
- ensuring that membership contributions are up to date at all times
- abiding by all fund rules
- advising us of any change in contact details or circumstances that affect any of the people covered by the membership.

Authorised people

Partner authority

The principal member is the only person with an automatic entitlement to alter the membership, submit claims and receive benefit payments. By putting a simple 'partner authority' in place, the principal member can authorise his or her partner / spouse (if they are named on the membership) to operate the membership in exactly the same way as the principal member can, with the exception of being able to suspend or cancel it – only the principal member can do that.

A 'partner authority' can be put in place at the time of joining by ticking the appropriate box on the application form, or at any time after that by completing a 'partner authority' form, or by simply ticking the 'partner authority' box on the membership in our online member centre.

To set up your partner authority online, or check if you already have one in place, visit our online member centre.

Legal authorities

We will recognise the authority of a third party to make claims and changes to a membership where a general or enduring power of attorney is in place.

We do not recognise a 'guardianship' as authority to deal with us on behalf of someone else's membership. While guardianship allows the guardian to make many decisions about someone's living arrangements and medical treatment, it does not usually extend to making financial decisions.

Third party authority

The principal member can nominate someone who is not covered by the membership to make changes, ask about claims and generally manage the membership on his or her behalf by completing a 'third party authority' form.

Making changes to your membership

Changes you make

Changes in your circumstances

If there is a change in your circumstances that would affect your membership (such as a change to the people covered), please let us know as soon as possible to ensure that your membership remains valid.

Changing your contact details

Please remember to let us know as soon as possible if any of your contact details change so we are able to keep you informed about your cover, and so we can make sure claim payments find their way to you quickly.

To check and change your address details online, visit our online member centre.

Moving interstate

The price of cover can vary between states, so a move interstate may either increase or decrease the cost of your health cover.

Ambulance cover arrangements also differ significantly between states. Please make sure you understand what the Ambulance cover arrangements are if you move interstate.

Changing your level of cover

Changing your level of cover may affect the amount you pay and the benefits you receive. If you upgrade to a level of cover that includes benefits you were not previously entitled to, you may have to serve a waiting period before you can claim the higher benefits (this applies to both new benefits and increased benefit limits). When you upgrade your Extras cover, any benefits you've already claimed under your previous level of cover will be taken into account until the benefit limits reset on 1 January.

Changes we make

If there is a change in legislation or a change in our fund rules or policies that will adversely affect your membership and / or benefits, we will notify you in writing. Depending on the issue, this may be through a personally addressed letter, via email or through other communication.

Cancelling your membership

Cancellation at your request

Membership cancellations must be requested in writing by the principal member, and specify the date of cancellation. We are not able to backdate a cancellation, which means the effective date of a cancellation cannot be before the date the cancellation request is received. This does not affect your cancellation rights during the cooling off period.

Because membership contributions are usually paid in advance, the principal member is entitled to a refund of any contributions paid in advance of the cancellation date.

Any adult or dependant child who is 18 or older can cease his or her own cover under a membership by giving written notice, but they cannot cancel the entire membership.

Cancellation by Transport Health

There are some circumstances under which we exercise our right to cancel a membership. These include:

- where the contribution payments are 90 days in arrears
- where a member provides false or misleading information in any correspondence or claims

or where a member has:

- acted in a manner detrimental to the fund
- received, obtained, or attempted to receive or obtain, any advantage to which they are not entitled under the fund rules, or
- obtained membership by misrepresentation or mistake.

Need a form?

All the forms you need can be downloaded from the 'Members' section of our website. We'd also be happy to send you one.

Types of membership

We offer a choice of four different membership types, depending on whom you want to cover:

1. Single
Covers one adult.

2. Couple
Covers two adults.

3. Sole-parent family
Covers one adult and all dependent children, whether the children live with you full-time or not.

4. Family
Covers two adults and all dependent children of either or both adults.

Cover for the kids
Dependent children are the natural, adopted, stepchildren or foster children of either or both adults on the membership. They can remain covered by a family or sole-parent family membership right up until their 21st birthday, provided they are not married or living in a de facto relationship.

- **If you have a family or sole-parent family membership** – you can add additional dependent children at any time, and at no additional cost. If they've never been covered by health insurance before, they may have waiting periods to serve. We'll talk to you about your individual situation when you contact us.
- **If you have a single membership** – you'll need to upgrade to a family or sole-parent family membership in order to cover the kids, and this will increase the cost of your health cover.

Student dependants – full-time students aged 21 to 24 years

After the age of 21, children may be eligible to remain covered as student dependants until their 25th birthday.

Student dependants are young adults covered by a family or sole-parent family membership who are:

- aged 21 to 24 years
- not married or living in a de facto relationship, and
- enrolled and attending an approved apprenticeship or full-time student at a school, college or university.

Student dependants must be registered each year in order to remain covered. Once you have a student dependant registered on your membership, we'll write to you at the beginning of each year to ask you to reconfirm their student status. If we haven't heard from you by the deadline for re-registration, your student dependant child will be removed from your cover. We will send you a letter to confirm the change, and will issue you with new membership cards showing that his or her name has been removed.

Part-time students and part time apprentices are not eligible for cover as student dependants.

Family extension – part-time students, apprentices or working adult children aged 21 to 24 years

We offer a level of cover for adult children who are not eligible to be covered as a student dependant for a fraction of what they'd pay for their own individual health cover. This option is only available when you hold a sole parent or family combined cover of Gold Top Hospital and Top Extras.

Once the kids turn 25 …

Once they're 25, it's time for the kids to get their own cover. If they transfer to their own membership within two months of leaving yours, and join an equivalent or lower level of cover, they'll have no waiting periods to serve.

New babies

Babies are not admitted to hospital at the time of birth (mum is, but baby is not). They are only admitted in their own right if they have a medical condition that requires treatment.

If you're lucky enough to be having a multiple birth, your first baby is not admitted to hospital (unless he or she requires individual medical treatment) but each subsequent baby will automatically be admitted and will be charged for accommodation.

In order to make sure that your baby is fully covered from the time of birth, you may need to upgrade the type of membership you have to a sole-parent or family cover.

Provided you have Hospital cover that includes pregnancy and you have served your 12-month waiting period:

- **If you have a single membership** – you'll need to upgrade to a family or sole-parent family membership at least two months before the expected date of delivery. There will be an increase in the cost of your cover. If you wait until after the birth to upgrade your cover, your baby may have to serve waiting periods, which means that he or she will not be covered for immediate treatment.
- **If you have a couple, family or sole-parent family membership** – your new baby will be covered immediately from birth. All you need to do is drop us a line before he or she is twelve months old, so we can add him or her to your membership without any waiting periods applying. There is no additional cost to add your new baby to your cover.

Silver Plus Smart Choice Hospital No Pregnancy, Bronze Plus First Choice, Bronze Plus Healthy Choice and Bronze Plus Young Singles and Couples Hospital covers exclude pregnancy. If you have any of these levels of cover, you must wait 12 months from the time you upgrade to a higher level of Hospital cover before you are covered for pregnancy.

Can we help?

If you have any questions, our team is here to help. Contact us on **1300 806 808** or email us at **enquiries@transporthealth.com.au**

Making a claim

The process for making claims is different for Hospital and Extras cover. Please see page 20 for making Hospital cover claims, and page 31 for Extras claims.

Overseas products and services
Your health cover does not pay benefits for products, services or treatments purchased from or provided by practitioners overseas, whether you buy them in person, by mail or online.

When you travel overseas, it is possible to suspend your membership, as you are not able to make use of it while you are out of the country.

Read more about suspending your membership on page 12.

Time limit for submitting claims
You have up to two calendar years from the date of purchase, service or treatment to submit your claim.

Claims during waiting periods
You are not entitled to receive any benefit for products, services or treatments you receive or purchase during your waiting period.

Compensation claims
You are not covered for products, services or treatments you receive as a result of an incident for which you are entitled to claim compensation or damages from a third party.

In this situation, it is possible to request an ex gratia payment from us which will help you to cover the upfront costs. If granted, we pay the initial costs and you agree to repay the sum when the third party claim is resolved.

In this situation, it is possible to ask us to pay the claims to cover the upfront costs provided you provide us with all information to enable us to recover these costs from the third party. To the extent we are unable to recover these costs from the third party we will recover them from you.

Ex gratia benefits
An ex gratia benefit is a special payment for a product, service or treatment that is not actually covered by the fund under the relevant policy. Applications for ex gratia benefits are assessed on a case-by-case basis.

This type of arrangement is completely discretionary, it is not a standard entitlement of your membership.

Incorrect payments
If we pay a benefit in error, we are entitled under our fund rules to recover any amount mistakenly paid.

Fraudulent claims
We treat fraudulent behaviour very seriously. When we evaluate our products and pricing each year, we take many things into account, but the volume and cost of claims are among the key drivers of how much your health cover costs. Fraudulent claiming drives the cost of health cover up for all members.

Fraudulent claims can come from many different sources, including health service providers and members. If you become aware of (or suspect that you may have been exposed to) fraudulent claiming, please contact us.

Making payments

The model for setting health cover prices is generally the same across the entire health insurance industry.

Community rating

Private health insurance in Australia is 'community rated', which means that anyone is entitled to buy any health cover product offered by any fund at the same price, regardless of his or her medical history, age, gender or ethnicity.

In other words, unlike other types of insurance, health insurance is not 'risk rated.' Community rating provides everyone with access to affordable health insurance by preventing health insurers from charging some people more for their cover than others based on their age, health or claims history. An exception to community rating is the government's Lifetime Health Cover (LHC) program, which increases the price of Hospital cover for people who have an LHC loading. Another exception is Age-based discounts - an optional discount which health funds can apply for younger members.

Read more about Lifetime Health Cover and loadings on page 38.

Contribution increases

The process for increasing the amount you pay for your health cover is strictly regulated by the government. Once each year, according to a timetable set by the Australian Government Department of Health, health funds make a submission to the government if they need to increase members' contributions. The government assesses contribution increase applications in order to ensure that they are the minimum necessary, and that they are in the interests of members. It may then either approve the increase or require funds to resubmit their requests.

If your contribution rates are going to change, we will advise you in writing before the change is due to take effect. This will generally happen in March each year, with rate increases usually taking effect on 1 April each year.

Rate protection

Following the announcement of a rate increase, we give members the opportunity to pay their contributions up to one year in advance of the date of the increase at the current price. Members are advised of this opportunity and the deadline for pre-increase payments.

Keeping your payments up to date

Your contributions must always be paid in advance, unless you are paying by salary deduction. For example, if you choose to pay monthly, each payment you make covers you for the month ahead.

If your payments fall behind, your ability to make on-the-spot claims using HICAPS will cease immediately because when you swipe your membership card through the payment terminal, it will identify your membership as being 'unfinancial.'

If your contributions have fallen behind, any outstanding payments must be brought up to date before you can receive benefits for any product, service or treatment received while your membership contributions were unpaid.

We will terminate your membership if it remains unpaid after 90 days.

Payment methods

There are plenty of options available when it comes to paying your contributions:

Direct debit

You can pay your contributions by direct debit from a bank, building society or credit union account, or from your MasterCard or Visa. If you choose to pay by direct debit, there are a few things to remember:

- You can choose to pay weekly, fortnightly, monthly, quarterly, half-yearly or yearly.
- If your debit day falls on a weekend or public holiday, your payment will be deducted on the next working day.
- If you're paying by credit card and your card is lost or stolen, please let us know immediately, so we can cease debits from that card and set up a new debit with your replacement card.
- If the card your debits are being made from expires without you notifying us of your new card details, the debit will fail and a bank dishonour fee will be incurred.
- If you want to change or cancel a direct debit, we need to know at least 10 business days before your next debit is due to occur, so we have time to process your request.
- If a direct debit is unsuccessful for two consecutive payments, the arrangement will be ceased and you will need to complete a new direct debit authority if you wish to recommence direct debit payments.

To update your account or credit card details, or download a direct debit form, visit our online member centre.

Billing notice

We can send you a monthly, quarterly, half-yearly or yearly account which can be paid by:

- *Online*
  You can pay online in our Member Service portal https://members.transporthealth.com.au/
- *BPAY*
  Via telephone or online banking
  Our biller code is 170522
- *Credit Card*
  Call our member care team on **1300 806 808**

Salary deduction

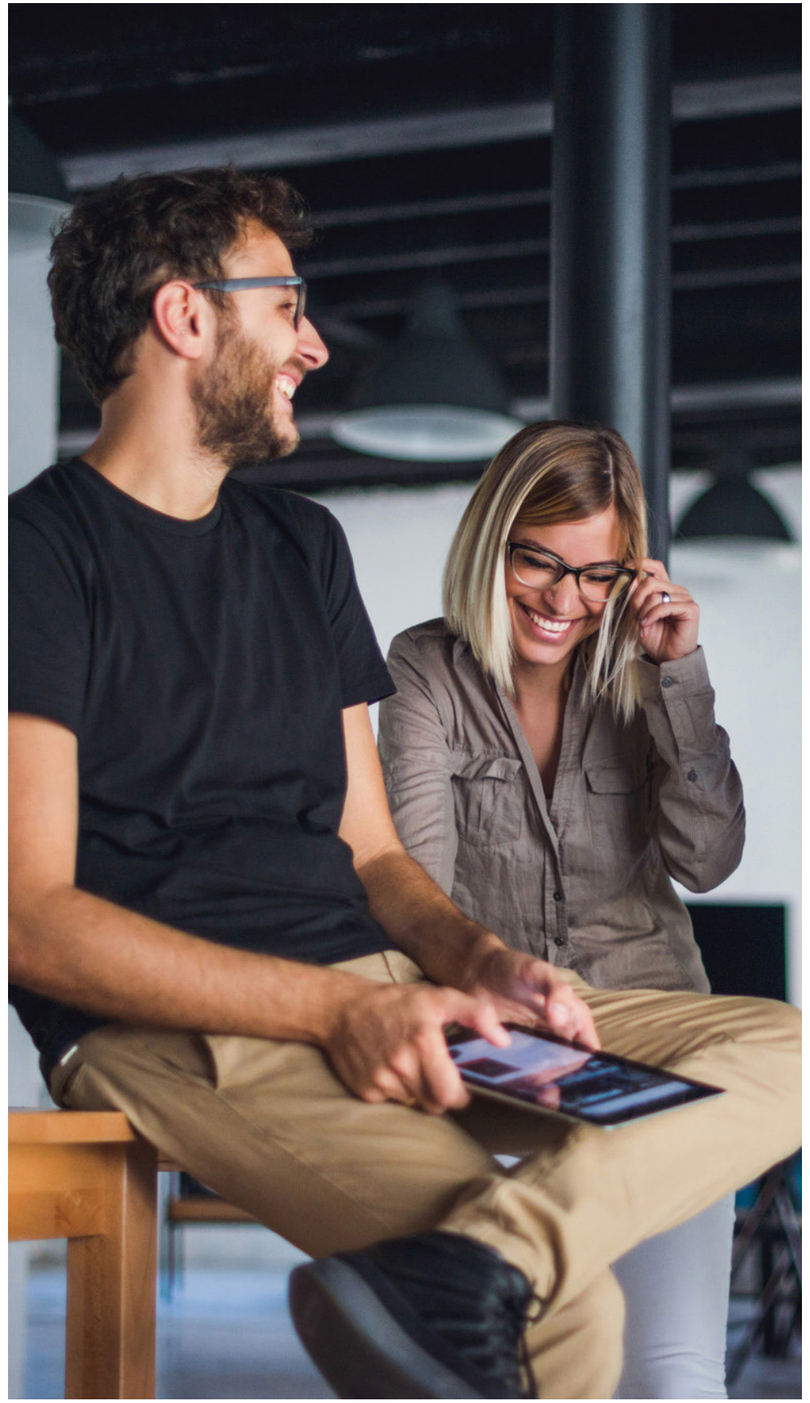
Your HR department, or our member care team, can tell you if there is a salary deduction arrangement in place with your organisation. If there is, you can choose this option at the time you join or at any time later by completing a salary deduction form. If there isn't a salary deduction program already in place, speak to us or your employer about getting one started.

When you first start paying by salary deduction, there may be a payment adjustment required to cover the period of time from when your cover commences to when your first deduction occurs. This is because salary deductions are fixed at a set amount of money, paid for a set amount of time. For example, your salary deduction might be timed to occur once a month, but you want your cover to commence two weeks before the next deduction is due to take place, so there would be an additional two-week payment required to bring your cover into line with the next salary deduction. We will contact you to advise you of this amount (if any).

Unlike all other payment methods, salary deduction payments cover the period just ended, rather than the period in advance. If you change to another method of payment, you will need to make a payment adjustment to begin making payments in advance.

With four weeks' notice, Transport Health may choose to remove the option of salary deduction from your organisation.

Call our contact centre to request a salary deduction form.



Suspending your Transport Health membership

Memberships can be suspended for two reasons:

1. overseas travel for work or leisure
2. financial hardship.

The minimum period of suspension is 28 days, and the maximum is two years for overseas travel.

Suspending your Hospital cover does not count toward your number of 'absent days' for Lifetime Health Cover (LHC) purposes, but it may result in you being liable to pay the Medicare Levy Surcharge (MLS).

We recommend you speak to your accountant, tax agent or the Australian Taxation Office (ato.gov.au) if you need further advice about how a membership suspension will affect you.

Read more about 'absent days' and the Medicare Levy Surcharge on page 39.

Can we help?
If you have any questions, our team is here to help. Contact us on **1300 806 808** or email us at **enquiries@transporthealth.com.au**

The following criteria apply to all membership suspensions:

- If you are travelling overseas on holidays, your health cover can be suspended for any period from a minimum of 28 days to a maximum of two years.
- You must be overseas for the entire duration of your membership suspension. For example, it is not possible to suspend your membership for 28 days if you are going to be overseas for any period less than 28 days.
- A membership suspension applies to the entire membership and each person covered; you cannot suspend just the Hospital or just the Extras part of your membership; you cannot suspend one person's cover while continuing cover for other people named on the membership; you cannot suspend the membership if all people covered by it are not travelling overseas.
- The principal member is the only person with authority to request a membership suspension.
- You must have held your Transport Health membership for a minimum of 12 months before it can be suspended.
- Your membership must be paid up to the date of your departure before it can be suspended.
- Any contributions you've paid in advance of the date of your departure will be credited to your membership when it is reactivated.
- Suspension requests should be submitted at least two weeks before you leave Australia; it is not possible to backdate a membership suspension.
- There must be a minimum of six months between the end of one period of suspension and the beginning of another period of suspension. The 'beginning' of any period of suspension is considered to be the first full day you are out of the country.

To download a membership suspension form, visit our online member centre.

To reactivate your membership:

In order to reactivate your membership, you must provide proof of travel for each person covered by the membership within 30 days of returning to Australia:

- Members travelling for less than three months can provide boarding passes for flights out of and into Australia or a stamped passport showing dates of departure and return. Your cover will be reinstated from the date of your return to Australia
- Members travelling for three months or more must supply a Certificate of Movement from the Department of Immigration and Citizenship.
- Members traveling by sea for any length of time can provide copies of your cruise boarding cards and cruise itinerary.

Travel itineraries or e-tickets cannot be accepted as proof of travel.

If you are unable to provide proof of travel for each person covered, your suspension will be revoked and any outstanding contributions for the period of suspension will be payable.

- Following a period of suspension, your membership will become active again when the membership has been reactivated and contribution payments have recommenced. Where contributions have been made in advance, the membership must still be reactivated before claims can be made. Your cover will be reinstated from the date of your return to Australia.
- You may become liable to pay the Medicare Levy Surcharge while your membership is suspended if your income exceeds the Medicare Levy Surcharge thresholds. Please discuss this with your accountant or tax advisor.

What does your Hospital cover pay for?

We have seven options when it comes to choosing a Hospital cover:

1. Gold Top Hospital

This is our top-level Hospital cover. It gives you access to treatment by the doctor of your choice and a private room in a private hospital we have a contract with or public hospital of your choice.

This cover is available with no excess.

2. Silver Plus Select Hospital

This is a comprehensive level cover but does have restrictions. It gives you access to treatment by the doctor of your choice and a private room in a private hospital we have a contract with or a public hospital of your choice.

This cover includes a restriction on psychiatric services. The details of this cover are listed on page 19, as well as in the detailed cover guides on pages 44-45.

This cover is available with a $500 excess or a $100 daily excess.

3. Silver Plus Smart Choice Hospital No Pregnancy

This is a high-level cover that gives you access to treatment by the doctor of your choice, and a private or shared room in a private hospital we have a contract with or public hospital of your choice.

This cover has exclusions (things that are not covered) and restrictions (things that you are covered for in a public hospital). These are listed on page 19, as well as in the detailed cover guides on pages 46-47.

This cover is available with a $500 excess or a $750 excess. The excess for individual day surgery procedures is capped at $100.

4. Bronze Plus First Choice Hospital

This level of cover is for people who are just starting out with health cover. It gives you access to treatment by the doctor of your choice, and a private or shared room in a private hospital we have a contract with or public hospital of your choice.

It has exclusions (things that are not covered) and restrictions (things that you are covered for in a public hospital). These are listed on pages 19 as well as in the detailed cover guides on pages 48-49.

This cover is available with a $700 excess.

5. Bronze Plus Healthy Choice Hospital

This is our entry-level cover that gives you access to treatment by the doctor of your choice, and a private or shared room in a private hospital we have a contract with or public hospital of your choice.

This cover has exclusions (things that are not covered) and restrictions (things that you are covered for in a public hospital). These are listed on page 19, as well as in the detailed cover guides on pages 50-51.

This cover comes with a $100 daily excess.

6. Basic Plus Public Hospital

This cover gives you access to treatment as a private patient in a public hospital, but you may face considerable out-of-pocket costs for treatment in a private hospital. Public hospital waiting lists still apply and you will not be given priority over public patients. The timing of your treatment will be subject to the individual hospital's bed availability.

Please be aware that doctors usually work in a select few hospitals, which may limit the choice of hospitals available to you if you wish to be treated by a particular doctor. If you are to be treated in a private hospital we recommend you speak to us prior to admission to help identify the likely out-of-pockets you will bear.

There are no excess options with Public Hospital cover.

Read more about what's covered by each of these Hospital covers in the detailed cover guides on pages 42-61.

7. Silver Plus Smart Choice Hospital

Closed product only available to members who currently hold the cover

This is a high-level cover that gives you access to treatment by the doctor of your choice, and a private or shared room in a private hospital we have a contract with or public hospital of your choice.

This cover has exclusions (things that are not covered) and restrictions (things that you are covered for in a public hospital). These are listed on page 19, as well as in the detailed cover guides on pages 52-53.

This cover is available with a $700 excess and the excess for individual day surgery procedures is capped at $100.

8. Bronze Plus Young Singles/Couples Hospital

Closed product only available to members who currently hold the cover

This is part of a combined Hospital and Extras cover and is for people who are just starting out with health cover. It gives you access to treatment by the doctor of your choice, and a private or shared room in a private hospital we have a contract with or public hospital of your choice.

It has exclusions (things that are not covered) and restrictions (things that you are covered for in a public hospital). These are listed on pages 19 as well as in the detailed cover guides on pages 56-57. This cover comes with a $500 excess

Excess and Co Payments

With the exception of Gold Top Hospital and Basic Plus Public Hospital each of our hospital covers come with an excess.

An excess is an amount of money that you agree to pay to a hospital before your health insurance kicks in. You choose to pay an excess in return for a lower premium. If you do not go to hospital, you will not have to pay the excess, or co-payment. If anyone covered by your membership goes into hospital, your chosen excess is payable directly to the hospital.

If you have a single membership you will pay the full excess for any admission/s you have. Once you have paid the full excess you won't have to pay it again that calendar year.

If you have a couple's membership, each adult will pay the full excess for any admission/s they have. Once you have paid the full excess, you won't have to pay it again that calendar year.

If you have a single parent or family membership, the full excess will have to be paid twice in any calendar year. This can be split across two or more people. Once an individual has paid their full excess, they won't have to pay it again that calendar year.

If you have a daily excess, you will pay that amount per day of any hospital admission until the maximum per person or per membership is reached.

On some of our covers a day procedure excess applies. This amount is either equal or less than your chosen membership's excess or co-payment and does count towards your memberships maximum payable excess or co-payment.

Your Hospital cover pays benefits on six types of costs:

1. Private or public hospital of your choice

Depending on which one of our Hospital covers you have, you're covered for up to 100% of all hospital costs when you are treated in any public hospital, or a private hospital that Transport Health has a contract with, including day surgery facilities.

The hospital's costs relate to the use of its facilities, and include fees for your accommodation, use of the operating theatre, specialist wards, medical equipment, meals, nursing staff, and so on. We have contracts with most private hospitals and day surgeries in Australia and you're covered anywhere in the country, even if you're going into hospital outside of your home state. You can see which private hospitals we have a contract with on our website. If you choose to go to a private hospital that we do not have a contract with, you will be left with substantial out-of-pocket costs, which can often run to many thousands of dollars.

Please note, if you have cover for treatment in a private hospital, your ability to have a private room is dependent on the hospital having one available for you. If the hospital does not have a private room available, you may be accommodated in a shared room.

Each of our Hospital covers pays hospital costs differently:

Gold Top Hospital – is our top level of Hospital cover. It gives you access to the doctor of your choice in the private or public hospital of your choice, including private room accommodation where it is available. It comes with no exclusions and no restrictions; if Medicare pays a benefit on the procedure you're having in hospital, then so does Top Hospital.

Silver Plus Select Hospital – A comprehensive level of Hospital cover with restrictions. It gives you access to treatment by the doctor of your choice and a private room in a private hospital we have a contract with or a public hospital of your choice. This level of cover restricts hospital psychiatric services. For all other services, if Medicare pays a benefit on the procedure you're having in hospital, then so does Select Hospital.

Restrictions
You are covered as a private patient in a public hospital. In a private hospital, you will only receive minimum benefits and will incur significant out-of-pocket expenses.

– Hospital psychiatric services

Silver Plus Smart Choice Hospital No Pregnancy – covers you for up to 100% of the costs of a private or shared room in any public hospital or contracted private hospital or day surgery facility, with some exceptions.

Exclusions
You are not covered if you go to hospital for any of the treatments that are excluded from this cover:

– Pregnancy and birth (obstetrics)

– Assisted reproductive service

– Weight loss surgery

Restrictions
You are covered as a private patient in a public hospital. In a private hospital, you will only receive minimum benefits and will incur significant out-of-pocket expenses:

– Hospital psychiatric services.

Silver Plus Smart Choice Hospital – covers you for up to 100% of the costs of a private or shared room in any public hospital or contracted private hospital or day surgery facility, with some exceptions.

Exclusions
You are not covered if you go to hospital for any of the treatments that are excluded from this cover:

– Joint replacements

– Dialysis for chronic kidney failure.

Restrictions
You are covered as a private patient in a public hospital. In a private hospital, you will only receive minimum benefits and will incur significant out-of-pocket expenses:

– Hospital psychiatric services.

Bronze Plus Healthy Choice Hospital – is our entry level of Hospital cover, which gives you access to treatment by the doctor of your choice in the private or public hospital, of your choice, including private room accommodation where it is available.

Exclusions
You are not covered if you go to hospital for any of the treatments that are excluded from this cover:

– Joint replacements

– Dialysis for chronic kidney failure

– Heart and vascular system

– Cataracts

– Pregnancy and birth (obstetrics)

– Assisted reproductive services

– Weight loss surgery.

Restrictions
You are covered as a private patient in a public hospital. In a private hospital, you will only receive minimum benefits and will incur significant out-of-pocket expenses:

– Hospital psychiatric services

– Rehabilitation.

Bronze Plus First Choice Hospital – covers you for up to 100% of the costs of a private or shared room in any public hospital or contracted private hospital or day surgery facility, with some exceptions.

Exclusions
You are not covered if you go to hospital for any of the treatments that are excluded from this cover:

– Joint replacements

– Dialysis for chronic kidney failure

– Heart and vascular system

– Cataracts

– Pregnancy and birth (obstetrics)

– Assisted reproductive services

– Weight loss surgery

– Back, neck and spine

– Plastic and reconstructive surgery (medically necessary).

Restrictions
You are covered as a private patient in a public hospital. In a private hospital, you will only receive minimum benefits and will incur significant out-of-pocket expenses:

– Hospital psychiatric treatment

– Rehabilitation.

Bronze Plus Young Singles/Couples Hospital – is part of a combined Hospital and Extras cover package. It covers you for up to 100% of the costs of a private or shared room in any public hospital or contracted private hospital or day surgery facility, with some exceptions.

Exclusions
You are not covered if you go to hospital for any of the treatments that are excluded from this cover:

– Joint replacements

– Dialysis for chronic kidney failure

– Heart and vascular system

– Cataracts

– Pregnancy and birth (obstetrics)

– Assisted reproductive services

– Weight loss surgery

– Back, neck and spine

– Insulin pumps.

Restrictions
You are covered as a private patient in a public hospital. In a private hospital, you will only receive minimum benefits and will incur significant out-of-pocket expenses:

– Hospital psychiatric services

– Rehabilitation

– Palliative care.

2. Doctors of your choice

When you are treated as an inpatient in hospital, each of the doctors who treats you will charge a fee for his or her services. Responsibility for paying these fees is split between Medicare, your private hospital cover and you.

Medicare reimburses you for 75% of the MBS (Medicare Benefits Schedule) fee and your Hospital cover pays the remaining 25%. Out-of-pocket costs can arise because doctors are not restricted to only charging the MBS fee. Any amount your doctor charges above the MBS fee is an amount you are responsible for paying.

Read more about the MBS fee on page 20.

There is a program called Medicover that can help you to reduce or eliminate your out-of-pocket costs by making certain arrangements with your doctors before you go into hospital. The way it works is that you ask your doctors if they will participate in Transport Health's Medicover at the time you are making arrangements for your hospital stay. If your doctors agree, it means they are willing to accept a set fee for their services that is more than the MBS fee, but probably less than what they might otherwise charge. This means your Hospital cover can pay a fixed amount that is higher than the standard 25% of the MBS fee, and as a result you are likely to have lower out-of-pocket costs, and in many cases, none at all.

You can look up doctors who currently participate in our Medicover on our website. If you don't find your doctor's name on this list, it doesn't mean that they won't participate, but perhaps they haven't done so with a Transport Health member before. You are free to ask any doctor who is going to treat you if they are willing to participate.

Each of our Hospital covers pays doctors' fees in the same way, and you have the same level of cover for doctors' fees with each.

If you have Silver Plus Smart Choice No Pregnancy, Silver Plus Smart Choice, Bronze Plus First Choice, Bronze Plus Healthy Choice or Bronze Plus Young Singles/Couples Hospital covers, you will not be eligible to claim any doctors' fees if you are treated for any of the items that are specifically excluded from these covers. The treatments that are excluded under Silver Plus Smart Choice No Pregnancy, Silver Plus Smart Choice, Bronze Plus First Choice, Bronze Plus Healthy Choice and Bronze Plus Young Singles/Couples Hospital covers are listed on page 19 and in the detailed cover guides on pages 42-61.

3. & 4. Implanted prostheses and in-hospital pharmaceuticals

Prostheses include things like artificial hip or knee joints, cardiac devices such as pacemakers or defibrillators and so on – think of them as being any 'artificial body parts'. Pharmaceuticals include any type of medication, whether it is anaesthesia, pain reduction medication or other specialist medication related to the treatment of your condition.

Most prostheses and pharmaceuticals are fully covered, but there are a few restrictions on the types of products we can pay for. These restrictions apply to items that are not covered by the government's Prostheses List or Pharmaceutical Benefits Scheme (PBS). For those few items that are not fully covered, you will have out-of-pocket costs.

If your doctor advises you that you need to have a prosthesis fitted, ask him or her to let you know what the prosthesis item number is and our member care team will be able to let you know if you should expect any out-of-pocket costs. In the case of medications, you can ask your doctor in advance if they plan to prescribe anything to you that is not covered by the PBS and then speak with us about whether we can pay benefits on it.

Each of our Hospital covers pays prostheses and pharmaceutical fees in the same way, and you have the same level of cover with each. Silver Plus Smart Choice No Pregnancy, Silver Plus Smart Choice, Bronze Plus First Choice, Bronze Plus Healthy Choice and Bronze Plus Young Singles/Couples Hospital covers combined do not receive any prostheses or pharmaceutical benefits for treatments that are excluded. You may not be eligible to claim any prostheses or pharmaceutical costs if you are treated for any of the items that are specifically excluded from these covers. The treatments that are excluded under Silver Plus Smart Choice No Pregnancy, Silver Plus Smart Choice, Bronze Plus First Choice, Bronze Plus Healthy Choice and Bronze Plus Young Singles/Couples Hospital covers are listed on page 19 and in the detailed cover guides on pages 42-61.

5. Ambulance attendance and transportation

Depending on where you live and and provided you hold hospital cover, you are covered for emergency and / or non-emergency ambulance attendance and transportation.

There are different arrangements in place for residents of different States and Territories. This will impact the extent to which you are covered.

The level of Ambulance cover you have with Transport Health is based on the residential State or Territory the policy is held in. If you or anyone listed on your policy lives in a different State or Territory to the residential address of the policy, please contact our team to check what cover you have.

6. Travel and accommodation expenses

Travel

The travel benefit is designed to help members with the costs when it is essential to travel a return journey of more than 200km to undertake specialist medical, dental or hospital treatment. It is intended to assist members who live in areas where they don't have access to the treatments they need closer to home, rather than for people who are travelling to receive treatment by choice.

Claims must be accompanied by a letter from the referring doctor. Individual limits apply. Please refer to the individual cover guides on pages 42-61.

Accommodation

The accommodation benefit is available to help with the costs where a parent or carer needs to stay away from home overnight to help an Transport Health member receive inpatient hospital care. The benefit is only available where the member receiving treatment is staying in hospital and the carer is staying in the accommodation. The costs of food and other items associated with the accommodation are not included.

Benefits can only be paid after a claim for the hospital treatment has been received. Individual limits apply. Please refer to the individual cover guides on pages 42-61.

What's not paid for by your Hospital cover

These are the things your Hospital cover does not pay benefits for:

Treatments and procedures not covered by Medicare

Your Hospital cover only pays full benefits for treatments that are recognised and subsidised by Medicare. If the treatment or procedure you're having cannot be claimed under Medicare, your normal cover entitlements won't apply. You will have substantial out-of-pocket costs for these procedures.

Non-medically necessary elective cosmetic surgery cannot generally be claimed under Medicare. If you choose to have such a procedure, we can only pay a 'default benefit' toward the cost of your hospital accommodation, and you will have substantial out-of-pocket costs, which can often run to many thousands of dollars.

Find out more about 'default benefits' on page 21 and read more about the Medicare Benefits Schedule on page 20.

Admission to a non-contracted private hospital

If you receive treatment in a private hospital that we do not have a contract with, we will pay a 'default benefit' toward the cost of your accommodation, but no other benefits are payable. You will have substantial out-of-pocket costs.

Find out more about 'hospital contracts' and 'default benefits' on page 21.

Hospital or medical costs for outpatient treatment

Your Hospital cover can only pay benefits for treatment you receive as an inpatient, that is, when you are admitted as a patient to hospital. Outpatient medical services are not covered. This includes visits to GPs and specialists, as well as treatment you receive in hospital as an outpatient or in an emergency department. Outpatient medical care can only be claimed through Medicare. It will pay 85% of the MBS fee and the remaining 15% (plus anything your doctor charges above that) is a cost that you will be responsible for paying. Bulk-billing doctors set their fees at the amount covered by Medicare (that is, they only charge 85% of the MBS fee), which is why there is no cost to you when you see a bulk-billing doctor.

Private hospital emergency department fees

When you are treated in an emergency department, you are an outpatient (you have not yet been admitted to the hospital). No benefits are payable for outpatient treatment.

Most public hospital emergency departments will treat you as a public patient at no cost. Some private hospitals also have emergency departments, and if you attend one of these, you are not covered for the costs.

Discharge pharmaceuticals

These are items prescribed for you to take home after you are discharged from hospital. No benefits are payable for these under your Hospital cover, but you may be able to claim under your Extras cover.

Other non-contracted fees, benefits and services

Your Hospital cover does not pay benefits for additional products or services, such as television hire, internet access, phone calls, purchase of newspapers, purchase of medication not related to the reason for your admission, and fees above the contracted or default amount.

Treatment provided in non-hospital facilities

Your Hospital cover does not pay benefits for nursing home, aged care, respite care or palliative care facilities.

Sometimes, a person may remain in hospital following a treatment or procedure while waiting for a position in a nursing home to become available. These people are referred to as 'nursing home-type patients.' The benefit we pay toward the care of nursing home-type patients does not fully cover the amount that will be charged by the hospital. If you are in this situation, the hospital will advise you of the anticipated cost of this service.

1300 806 808
enquiries@transporthealth.com.au

Treatments that are excluded

Applies to Silver Plus Smart Choice No Pregnancy, Silver Plus Smart Choice, Bronze Plus First Choice, Bronze Plus Healthy Choice and Bronze Plus Young Singles/Couples Hospital covers.

Exclusions help to reduce the price of these covers by not paying benefits on specific treatments. You are not entitled to claim any benefits for any of the following:

Smart Choice Hospital No Pregnancy	• Pregnancy and birth (obstetrics) • Assisted reproductive services • Weight loss surgery.
Smart Choice Hospital	• Joint replacements • Dialysis for chronic kidney failure.
Healthy Choice Hospital	• Joint replacements • Dialysis for chronic kidney failure • Heart and vascular system • Cataracts • Pregnancy and birth (obstetrics) • Assisted reproductive services • Weight loss surgery.
First Choice Hospital	• Joint replacements • Dialysis for chronic kidney failure • Heart and vascular system • Cataracts • Pregnancy and birth (obstetrics) • Assisted reproductive services • Weight loss surgery • Back, neck and spine • Plastic and reconstructive surgery (medically necessary).
Young Singles/Couples Hospital	• Joint replacements • Dialysis for chronic kidney failure • Heart and vascular system • Cataracts • Pregnancy and birth (obstetrics) • Assisted reproductive services • Weight loss surgery • Back, neck and spine • Insulin pumps.

Treatments that are restricted

Applies to Silver Plus Select, Silver Plus Smart Choice No Pregnancy, Silver Plus Smart Choice, Bronze Plus First Choice, Bronze Plus Healthy Choice and Bronze Plus Young Singles/Couples Hospital covers.

Restrictions help to keep the price of these covers down by limiting cover for specific treatments and services to treatment as a private patient in a public hospital, or minimum benefits in a private hospital (this will lead to significant out-of-pocket expenses).

Select Hospital	• Hospital psychiatric services
Smart Choice Hospital No Pregnancy	• Hospital psychiatric services
Smart Choice Hospital	• Hospital psychiatric services
Healthy Choice Hospital	• Hospital psychiatric services • Rehabilitation
First Choice Hospital	• Hospital psychiatric services • Rehabilitation
Young Singles/Couples Hospital	• Hospital psychiatric services • Rehabilitation • Palliative care

If you choose to receive treatment for any of these in a private hospital, you will receive a ‘default benefit’ toward the cost of your accommodation, but you will have substantial out-of-pocket costs, which can often run to many thousands of dollars.

Find out more about ‘default benefits’ on page 21.

Read more about what’s covered by each of these Hospital covers in the detailed cover guides on pages 42-61.

What happens when you go to hospital?

Planned hospital stays

When you are booking your hospital stay, you'll be asked if you have Hospital cover. If you say yes, the hospital will ask for your membership card, and will contact us to confirm the level of cover you have and make sure your cover is paid up to date.

If you have an excess, it is payable directly to the hospital. The admissions staff will let you know whether you need to pay it before you are admitted or at the time of your admission. Refer to the detailed cover guides on pages 42-61 for the specific conditions around excess payments for the cover you have.

If you have a hospital stay coming up, we strongly recommend that you call us for advice about how to make the most of your Hospital cover, and to confirm that you are covered for the procedure you're having.

Our 'Hospital at Home' program can be of benefit where hospital-equivalent treatment can be delivered to you at home, helping to avoid or shorten the length of a hospital stay, find out more on page 23.

Unplanned hospital stays

If you are taken to hospital as a result of an accident or emergency, you are likely to be taken to a public hospital emergency ward. If the hospital decides that you need to be admitted, you will be asked if you have Hospital cover. If you say yes, you may be admitted as a private patient and you may end up with out-of-pocket costs that you aren't prepared for. You're not obligated to declare or to use your private hospital cover if it doesn't suit you – you have the option of choosing to be treated as a public patient under Medicare rather than using your cover.

Making hospital claims

When you leave hospital, generally all of the hospital's bills will be sent directly to us, but you will receive bills from all the different doctors who treat you.

If your doctors agreed to participate in our Medicover

Send your doctors' bills to us together with a completed claim form (available to download from our website, or ask our team to email or post one to you). With Medicover, your doctors will have either agreed to charge you no gap, or they will have given you a quote in advance for any out-of-pocket costs you might have. You are responsible for paying any agreed out-of-pocket costs.

If your doctors did not participate in our Medicover

Take your doctors' bills to a Medicare office. They will pay 75% of the MBS fee and give you a statement that you send to us together with a completed claim form (available to download from our website, or ask our team to email or post one to you). We will pay the remaining 25% of the MBS fee. Any remaining amount is an out-of-pocket cost you are responsible for paying.

Medicare Benefits Schedule

The Medicare Benefits Schedule (MBS) is a listing of every treatment or procedure that has been identified by the government as being 'medically necessary.' These are the things that Medicare will pay a benefit on. Each treatment and procedure has been allocated a specific number that identifies it – referred to as the 'item number' – and every item has been assigned a set fee. The MBS fee is what your Medicare benefits and hospital cover rebates are based on.

For treatment provided to you by a doctor when you are admitted to hospital as a private patient, Medicare will pay 75% of the MBS fee and your private hospital cover, by law, is limited to only paying the remaining 25%. When you go into hospital, you are covered for 100% of the MBS fee for the medical treatments you receive.

Out-of-pocket costs arise because doctors are able to charge any amount they want for their services – they're not restricted to only charging the MBS fee. Any amount charged above the MBS fee is not covered by either Medicare or your Hospital cover; it's an out-of-pocket cost you are responsible for paying. This explains how you can end up with out-of-pocket costs even with hospital cover. The one exception to this is where your doctors agree to participate in our Medicover prior to you being admitted to hospital.

Medicover

Medicover (AGC) is a program that can help you to reduce or eliminate medical out-of-pocket costs when you receive treatment in hospital. The way it works is that you ask your doctors if they will participate in Transport Health's AGC at the time you are making arrangements for your hospital stay. If your doctors agree, it means they are willing to accept a set fee for their services that is more than the MBS fee, but probably less than what they might otherwise charge. This means you are likely to have lower out-of-pocket costs, and in majority of cases, none at all. You can search which doctors currently participate in our AGC on our website.

Doctors can choose whether or not to participate in AGC on a case-by-case basis, so you need to ask your doctors if they are willing to participate each time you require hospital treatment. It is something that needs to be agreed with each doctor who will treat you in hospital, which means having separate discussions with your surgeon, anaesthetist, pathologist and so on.

Informed financial consent

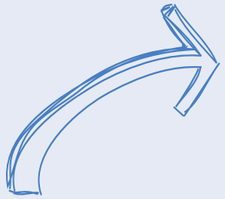
If you're going to be treated as a private patient in hospital, you are entitled to know how much your doctor/s will be charging you for their services. With this information in hand, you can also contact us to find out how much we'll be paying on your behalf and you will know in advance, how much (if any) your out-of-pocket costs will be. This is called Informed Financial Consent.

By asking your doctors about their fees before you go into hospital, you can make an informed decision as to whether you will go ahead with treatment with a certain doctor, or whether you'll 'shop around' for someone who will perform the treatment at a lower price.

Where possible, you should ask your doctor to provide you with information about how much they are going to charge you in writing. Where you have more than one doctor involved in your treatment – for example, a surgeon and an anaesthetist – you should contact each of the doctors involved and ask them about their fees, and if they will participate in our AGC. For more information on Informed financial consent visit the Commonwealth Ombudsman website at: www.ombudsman.gov.au

Pre-existing conditions

A pre-existing condition is any ailment, illness or condition where, in the opinion of a medical adviser appointed by the health insurer, the signs or symptoms of that illness, ailment or condition existed at any time in the period of six (6) months ending on the day which the person became insured under the Policy. The test applied under the law relies on the presence of signs or symptoms of the illness, ailment or condition; not on a diagnosis. It is not necessary for the member or their doctor to know what their condition is, or for it to be diagnosed. In forming an opinion about whether an illness is a Pre-Existing Ailment/Condition, the health insurer-appointed Medical Practitioner who makes the decision must consider information provided by the Member's treating doctor.



Important things to know about Hospital cover

There is a 12-month waiting period for hospital treatment needed as a result of a pre-existing condition (rules around pre-existing conditions only apply to Hospital cover, not Extras cover). The 12-month waiting period applies to all pre-existing conditions except for hospital psychiatric services, rehabilitation and palliative care.

If a claim looks like it may relate to a pre-existing condition, a medical advisor or practitioner appointed by us will examine information provided by your doctor/s and any other material relevant to the claim, and will make a determination as to whether the condition is pre-existing or not.

For people who have not held Hospital cover before, any hospital admission deemed to be due to a pre-existing condition will not be covered within the first 12 months. For people who have upgraded to a higher level of cover, and already served waiting periods at their previous level of cover, hospital admissions relating to a pre-existing condition within the first 12 months will be paid at the previous level of cover.

Waiting periods

When you first take out Hospital cover, rejoin after letting your cover lapse, or when you upgrade to a higher level of cover, you are required to serve waiting periods. For each person covered, the waiting period for a claim category starts on the first day the person is insured under the policy and ends at the time specified by the policy. During a waiting period you are not covered for the applicable services and you are not able to make claims or receive any payment or benefit for those services. Only services provided after the waiting period is completed are covered.

These are the standard waiting periods that apply:

- accidents and ambulance – 1 day
- general hospital treatment – 2 months
- wisdom tooth extractions – 2 months
- hospital psychiatric services, rehabilitation and palliative care – 2 months
- pre-existing conditions – 12 months
- pregnancy and birth (obstetrics) – 12 months
- assisted reproductive services – 2 months (Pre-existing rule conditions apply)

If you are transferring from another health fund where you have already served waiting periods on an equivalent level of cover, you don't have to serve them again with us.

Waiting period exemption for hospital psychiatric services

If you have held Hospital cover for at least the previous two months and have a referral for hospitalisation from an attending psychiatrist or addiction medicine specialist, you are able to access a government program to instantly upgrade your cover (at your expense) to include hospital psychiatric services for that hospitalisation. You can only access this program once in a lifetime. For more information, contact us on 1300 806 808 or visit privatehealth.gov.au and look under Mental Health – waiting period exemption for higher benefits.

Default benefits

A 'default benefit' is a minimum benefit that applies where you are not fully covered for hospital benefits. It contributes toward the cost of your hospital accommodation, but is not enough to fully cover the charges.

Where the default benefit applies due to the treatment or procedure not being claimable from Medicare, no benefits for doctors' fees, prostheses or pharmaceuticals will be paid. You will have substantial out-of-pocket costs. There are very few situations in which we only pay the default benefit, some examples include:

- where the treatment or procedure you're having is not claimable under Medicare
- where you are admitted to a hospital or day surgery that does not have a contract with Transport Health
- where you have Basic Plus Public Hospital cover and are admitted to a private hospital or day surgery
- where you have Silver Plus Select, Silver Plus Smart Choice, Bronze Plus First Choice, Bronze Plus Healthy Choice, Bronze Plus Young Singles/Couples Hospital cover and are admitted to a private hospital for any of the treatments that are specified as being restricted.

Hospital contracts

Health funds negotiate contracts with private hospitals to agree on set fees for the different types of services members receive in hospital. We have contracts in place with most private hospitals and day surgery facilities in Australia, which means that Transport Health members with the appropriate level of cover are up to 100% covered for all hospital expenses.

Health and wellbeing programs

Each of our Hospital covers includes access to additional programs designed to improve the type of care that you can access, and to help you to better manage your health and wellbeing.

Hospital at Home

Available with all Transport Health hospital covers, after two months of membership.

Our 'Hospital at Home' program can help you get home from hospital sooner, or avoid a hospitalisation altogether, by providing you with 'hospital equivalent' treatment and follow-up care in your own home. The program is available for all kinds of treatments and post-procedure support. If it is possible to provide the treatments you need in your home, and if you, your doctor and the hospital agree that it is appropriate for you, then we can help.

Our objective is to bring the hospital to you, so you can concentrate on your recovery in the comfort and privacy of your own home.

Here's how it works:

If your treating doctor agrees that hospital treatment at home is right for you, then our health services team will work in consultation with your doctor and hospital, arranging for you to receive all the services you need. All the people involved in your home treatment and recovery planning will be experienced health service providers with specialist knowledge of home-based hospital care, and the number and type of home visits you'll receive will be determined by your doctor.

How Extras cover works

You're probably more familiar with this being called Extras or Ancillary cover, but these days the health insurance industry calls it General treatment cover.

We have two options when it comes to choosing a general treatment or 'Extras' cover:

1. Top Extras

Top Extras is our higher-level Extras cover, which gives you excellent benefits on a huge range of services for your health and wellbeing. It is a great cover for people who are high users of particular healthcare treatments or services and those who want the level of benefits that come with having top cover. As our only Extras cover with benefits for orthodontic treatment, it's the ideal choice for families with growing smiles.

2. Healthy Choice Extras

Healthy Choice Extras is our low-level Extras cover, which gives you benefits on a huge range of services for your health and wellbeing. Healthy Choice Extras saves you dollars by excluding cover for orthodontic treatment. Its overall benefits are lower than our Top Extras cover, and most annual benefit limits are available 'per membership' rather than 'per person', so it's well suited to singles, couples or families who are moderate users of healthcare services.

3. (closed) Young Singles/Couples Extras

Young Singles/Couples Extras is part of a combined Hospital and Extras cover package. It gives you access to a range of services and allows you to choose where you want to claim your benefits.

Detailed cover guides showing what can be claimed under each of these products can be found on pages 42-61.

Extras cover is designed to help you out with the costs of healthcare services that you have outside of hospital and that aren't usually covered by Medicare. It works like a subsidy by paying a benefit each time you have a certain treatment or purchase a certain item.

Each of our detailed cover guides provides comprehensive information about what you're covered for, and how much you can expect to get back when you make your claim. There are, however, so many different things you can claim under some of the benefit categories (such as dental) that we can't list every type of service and benefit payment here. The information you need is readily available by calling our member care team on 1300 806 808.

There are a few things you need to know about how your Extras cover works:

Benefits

A 'benefit' is the amount we pay to you for the services you receive. In other words, it's the money you are entitled to get back from us when you make a claim for something that you're covered for.

Benefit limits

In our detailed cover guides, you'll see a range of benefit limits shown. A benefit limit is the maximum amount you can claim:

- per person
- per family
- per service
- or within a specified period of time.

These are the different types of benefit limits you might come across with our covers:

Annual limit

This is the maximum amount you can claim for a specific service within the calendar year.

Our annual limits expire on 31 December and reset again on 1 January.

You can't 'roll over' unclaimed annual limits into the following year.

Person limit

This is the maximum amount each person covered by the membership can claim for a specific service within the calendar year.

Per person limits may be restricted where there is an overriding family limit, sub-limit or lifetime limit.

You can't transfer unused 'per person' limits between the people covered by your membership.

Family limit

This is the maximum amount that can be claimed collectively by everyone covered by the membership for a specific service within the calendar year. Per person limits may still apply.

Sub-limit

This is a limit within a limit. Here's an example: our Top Extras cover has an annual limit of $400 per person/$800 per membership for health aids; however, a sub-limit of 80% of the cost up to $200 applies to each individual health aid. Sub-limits may also apply to other services in our Extras range.

Lifetime limit

This is a limit for the lifetime of your membership with Transport Health fund. The only lifetime limits we have are a $2,500 per person for orthodontic treatment and $500 per person for laser eye correction surgery under our Top Extras cover. Once this limit has been reached, no further benefits can be claimed for that person for the remainder of their membership, even if they leave the fund and return at some stage in the future.

Registered providers

Unlike doctors and hospitals, which are monitored by Medicare, there is no body that ensures only qualified, skilled and experienced practitioners provide the types of treatments covered by Extras. By only paying benefits on services received from registered providers, we help to ensure that our members are receiving care from properly qualified people.

As a general rule, we will pay benefits for healthcare services provided by:

- dentists registered with AHPRA (Australian Health Practitioner Regulation Agency
- registered optometrists or ophthalmologists
- natural therapists registered with the Australian Regional Health Group (ARHG).

  This group ensures that providers:
  - have full and proper qualifications
  - undertake ongoing professional development
  - have current first aid and insurance certification
  - belong to an accredited industry association.

If you go to a provider who is not registered with the ARHG, please give our member care team a call and they can offer advice as to how your provider can go about applying for registration. Registration of new providers can take a little while, but once we have been able to confirm their credentials, we will process and pay your claim.

There are a few natural therapy specialties that the ARHG does not administer. Where this is the case, your provider must be registered with the professional industry association shown on pages 27-28 before benefits can be paid.

Consultations

You are covered for one 'initial consultation' benefit per person, per therapy, per provider, each calendar year. If you receive a second 'initial consultation' from the same provider, charged in the same calendar year, you will receive the benefit that applies to 'subsequent consultations.'

You are not covered for fees incurred due to cancelled or missed appointments or consultations.

Products, services or treatments purchased in Australia

We only pay benefits where the transaction for your product, service or treatment takes place in Australia. If you purchase something overseas, order it online and the transaction takes place overseas, or have a treatment or procedure overseas, you are not covered.

Waiting periods

When you first take out Extras cover, rejoin after letting your cover lapse, or when you upgrade to a higher level of cover, you are required to serve waiting periods. For each person covered, the waiting period for a claim category starts on the first day the person is insured under the policy and ends at the time specified by the policy. During a waiting period you are not covered for the applicable services and you are not able to make claims or receive any payment or benefit for those services. Only services provided after the waiting period is completed are covered.

These are the standard waiting periods that apply:

- general dental – 2 months
- specialist therapies – 2 months
- health services – 2 months
- alternative therapies – 2 months
- optical – 6 months
- major dental – 12 months
- health aids – 12 months
- hearing aids – 24 months.

Refer to the detailed cover guides on pages 42-61 for a full list of waiting periods.

Can we help?

If you have any questions, our team is here to help. Contact us on **1300 806 808** or email us at **enquiries@transporthealth.com.au**

Products, services and treatments you are covered for

You can find a quick description of each of the products, therapies and treatments covered by Extras on pages 33-35.

Dental

General dental
Top, Healthy Choice and Young Singles/ Couples Extras Covers

Major dental
Top and Healthy Choice Extras Covers

Orthodontic
Top Extras Cover

Dental benefits are paid according to 'item numbers' determined by the ADA. Each item number describes a different dental product, service or procedure, and the ADA specifies a 'reasonable fee' for the service. Our benefits are a percentage of the amount you pay (as opposed to being a fixed amount for each item).

Similar dental services may have several different item numbers associated with them. For example, there are four item numbers that relate to 'scaling and cleaning', and which one your dentist chooses and charges you for can affect the benefit you receive.

We strongly recommend, where possible, that you ask your dentist for a quote detailing the item numbers of the services you'll be having, and then contact us so we can let you know exactly how much you'll be getting back.

Remember, the fees charged can vary significantly between dentists and, as with all types of healthcare services, you are within your rights to ask what the charges will be in advance, and to shop around for a dentist who charges a lower fee for the same service.

Orthodontic
Top Extras Cover

Orthodontic treatment has a lifetime limit.

The maximum amount payable to any one person for orthodontic treatment is $2,500. Once you've reached that limit, it is not possible to claim anything more for the remainder of your Transport Health membership, even if you leave the fund and rejoin again at some time in the future.

We strongly recommend that you contact us to discuss your orthodontic treatment plan, and the best way to maximise your orthodontic benefits, before you begin treatment.

Optical

Top, Healthy Choice and Young Singles/ Couples Extras Covers

Benefits are paid for any prescription frames, lenses, contact lenses or Irlen lenses.

You're not covered for the costs of:

- fitting fees
- LASIK / laser eye surgery (except under Top Extras - see cover guide)
- phakic lenses
- eye examinations

Pharmaceutical

Top and Healthy Choice Extras Covers

Benefits are paid for some pharmacy items that are prescribed by a medical practitioner, but not covered by the Pharmaceutical Benefits Scheme (PBS), EpiPens are a common example.

Benefits for Pharmacy are payable:

After deduction of the current PBS contribution set by the Commonwealth Department of Aging, on private prescription items (S4 and S8) which are:

i. prescribed by a Medical Practitioner;
ii. supplied by a registered pharmacist in Private Practice;
iii. Approved by the Therapeutic Goods Administration (TGA) for the indication for which they have been prescribed;
iv. not otherwise supplied or funded by a public arrangement scheme, including the PBS;
v. not otherwise Excluded by the Company.

Vaccines

Top and Healthy Choice Extras Covers

Benefits are paid for all medically-necessary vaccines, whether as part of a recommended immunisation program or for overseas travel.

Please note, while the cost of the vaccine can be claimed, the fee for the medical consultation in which the vaccination is provided cannot.

Claims must be submitted by an official pharmacy receipt or a receipt for the purchase of the vaccine from a doctor.

Therapies

The type of therapies covered, and the benefits you are entitled to claim, are dependent on the level of Extras cover you hold. Please refer to the individual cover guides on pages 42-61 for specific details about your level of cover.

Type of service	Notes		Provider registration required	Covered by
Chiropractic **Osteopathic**	If the receipt for your consultation shows a Medicare item number, this service can only be claimed under Medicare.	For treatments that can be claimed under Medicare or a third party, you cannot make an additional claim for the same treatment.	Medicare provider number	Top, Healthy Choice and Young Singles/ Couples Extras
Occupational therapy	If the receipt for your consultation shows a Medicare item number, this service can only be claimed under Medicare.			Top Extras
Orthoptics				
Physiotherapy	Physiotherapy benefits are paid for individual and group consultations.			Top, Healthy Choice and Young Singles/ Couples Extras
Dietetics	If the receipt for your consultation shows a Medicare item number, this service can only be claimed under Medicare.			Top Extras
Audiology	Benefits are only payable when you have been referred by a medical practitioner. If the receipt for your consultation shows a Medicare item number, this service can only be claimed under Medicare.			
Podiatry	If the receipt for your consultation shows a Medicare item number, this service can only be claimed under Medicare. Claims for biomechanical and gait assessments are limited to one per person, per calendar year.			Top and Healthy Choice Extras
Speech therapy	If the receipt for your consultation shows a Medicare item number, this service can only be claimed under Medicare.			Top Extras
Psychology	If the receipt for your consultation shows a Medicare item number, this service can only be claimed under Medicare. Benefits are payable for psychotherapy if performed by a registered psychologist. Benefits are not payable for counselling services or for psychology in relation to employment screening, motivational courses or marriage counselling.			

1300 806 808
enquiries@transporthealth.com.au

Therapies

Please note, benefits are payable for consultations only. The purchase of remedies, medicines, oils or other products is not covered.

Type of service	Notes	Provider registration required	Covered by
Acupuncture	If the receipt for your consultation shows a Medicare item number, this service can only be claimed under Medicare. You cannot make an additional claim for the same treatment under your Extras cover. Your practitioner will be able to advise you of whether the treatment can be claimed under Medicare.	Australian Regional Health Group arhg.com.au If the service is provided by a physiotherapist, or other allied health professional, they must also be registered as an acupuncturist with the ARHG in addition to their primary qualification.	Top Extras
Remedial massage		Australian Regional Health Group arhg.com.au	Top and Young SIngles/Couples Extras
Chinese medicine	Benefits are payable for consultations only – medicines and other remedies prescribed are not covered.		Top Extras
Myotherapy	Benefits are payable for consultations only – medicines and other remedies prescribed are not covered.		Top Extras and Healthy Choice Extras

Home nursing

Top Extras cover

Home nursing benefits are paid where the service is ordered by a registered medical practitioner, and provided by a registered nurse in private practice. Services provided by Blue Nurses and nursing groups or organisations may be claimed as long as the nurse who attends includes his or her registration details on the receipt or invoice.

Home nursing benefits are not paid for:

- dressings or disposables
- housekeeping support during or after confinement, except where certified as necessary for the mother due to a separate medical condition
- services provided by Tresillian or Karitane nurses
- donations.

Claims must be accompanied by a letter from the referring doctor and an itemised receipt showing the nurses full name and provider number.

Health aids

Top Extras cover

Benefits are payable in most cases for purchases only; hire or rental fees are only paid if specifically mentioned in the table below. No benefits are payable for consumables used in conjunction with any of these items.

Claims for health aids must be accompanied by a letter recommending the purchase (or hire, where covered) of the item by an appropriately qualified medical practitioner, specifying the full name of the person for whom the item is being recommended and the medical condition for which the aid is required.

Appliance or aid	Notes
Artificial eye	
Artificial limb	
Asthma Pump	
Blood glucose monitor	
Blood pressure monitor	
BPAP machine	
Breast/Mammary prosthesis and Bra	
Compression stocking (Surgical or Non Surgical)	
CPAP machine and masks	
Crutches	Benefits are payable for hire or purchase.
Custom made, moulded: • orthotics • Splints • Braces (back, knee and wrist)	Payable under your orthotics limit when you have a referral from a doctor/specialist.
Knee Walker/Moon Boots	
Low vision aids for ARMD (age-related macular degeneration)	Benefits only apply to non-electronic optical aids.
Nebuliser	
Oral Device Dental Item 983 and 984	
Oxygen/Oxygen Cylinder	
TENS machine	Benefits are not payable for circulation boosters, massagers or reflexology devices.
Wheelchair	Benefits are payable for hire or purchase.
Wig	

Making claims

Claiming requirements

Benefits are paid when:

- your membership is current at the time you purchase the product or have the service or treatment
- the service is performed in Australia by a provider recognised by Transport Health
- all relevant waiting periods have been served and the service was received after any relevant waiting period has been served
- the treatment is necessary or appropriate to the condition
- the claim is received within two years of the date of service
- the account or receipt is legible and has not been tampered with
- the service is not subsidised or payable by a third party (unless there is a prior arrangement with us)
- a legally enforceable debt is incurred
- the service or treatment is not provided by a healthcare practitioner who is either covered by the same membership, or who contributes to the payment of the patient's Transport Health membership.

Methods of claiming

Electronic claiming

Claims can be made electronically with practitioners who offer the HICAPS claiming facility. The types of practitioners that offer electronic claiming include dentists, optometrists, physiotherapists, psychologists, remedial massage therapists and many other providers of the types of services you would generally claim under an Extras cover.

If your practitioner offers HICAPS, simply present your Transport Health membership card at the time of paying your bill. Your practitioner will swipe your card through a terminal that sends information about the service you are paying for directly to us. The claim is lodged instantly and the benefit payable to you is calculated on the spot. All you do is pay the difference (if any) between the cost of the service and the amount of your benefit. You don't need to lodge a claim form or send in any receipts. It's all taken care of instantly.

> You can find out which practitioners offer HICAPS by visiting hicaps.com.au

Download our claims app

Submit your Extras claims via the Transport Health mobile app. You can download the mobile app from the Apple store for iOS mobile devices and the Google Play Store for Android mobile devices.

Once you have the app fill in your personal details, take a phot of your receipt and submit your claim.

The mobile app is designed to submit Extras claims with the exception of those claims that need to be submitted with a referral letter.

Claim forms

Claim forms must be signed by the principal member or a properly authorised third party.

They must be accompanied by appropriate documentation, such as receipts, accounts and in some cases, prescriptions or a letter from a medical practitioner. Any additional information needed is specified in the 'notes' section of the tables above.

You can download a claim form from our website.

Receiving claims payments

Direct credit – direct credit enables us to pay your claims benefits directly into your bank account rather than sending you a cheque. We can hold instructions to pay claims into one nominated account, but it is also possible to ask us to make particular payments into a different account on a claim-by-claim basis.

If you have authorised another person to manage your membership on your behalf, and they ask us to deposit a claim payment into a different account, we will abide by their request.

How Ambulance cover works

Ambulance cover

Except for residents of QLD who are covered under a state-based scheme, emergency ambulance cover is included with each of Transport Health's Hospital covers. Medicare does not cover ambulance costs, so for most people, without the right health insurance you would be expected to pay these fees yourself.

An emergency ambulance is when you need immediate transport by a state or territory ambulance to get to a hospital or other facility for urgent medical treatment. You are also covered when:

- An emergency ambulance is required and a paramedic treats you, but you aren't transported to hospital.
- You are transferred between hospitals because the hospital doesn't have the emergency treatment you need.

Your level of ambulance cover is based on the State or Territory the policy is held in so if you or any of the people listed on your membership live in a different State or Territory to the residential address of the policy, you will need to contact our team to check what level of cover you presently have.

The table below shows how ambulance cover works.

If your policy is in:	Transport Health Hospital cover will pay for costs associated with emergency ambulance use based on which State or Territory you reside in and in accordance with the particular coverage set out below against each State/Territory:
NSW or ACT	• unlimited cover • emergency transportation, and medically necessary non-emergency transportation • cover applies no matter where you are in Australia Please contact the fund prior to using any non-emergency patient transportation supplied by a hospital for inter-hospital transfers.
SA, WA and NT	• $5,000 per person, per year • emergency Ambulance attendance and transportation (no cover for attendance or non-emergency transportation) • cover applies no matter where you are in Australia You can take out a higher level of Ambulance cover, which includes emergency and non-emergency attendance and non-emergency transportation with these state-based organisations: South Australian Ambulance Service **saambulance.com.au** St John Ambulance Western Australia **stjohnambulance.com.au** St John Ambulance Northern Territory **stjohnnt.org.au**
VIC	• $5,000 per person, per year • emergency ambulance attendance and transportation (no cover for attendance or non-emergency transportation) • cover applies no matter where you are in Australia
TAS	• $5,000 per person, per year • residents of Tasmania are covered by a reciprocal state government ambulance scheme in all states except QLD and SA please see www.health.tas.gov.au – Ambulance Tasmania, fees and account, visiting other states for full details. Ambulance cover only applies where the state government scheme does not (no cover for attendance or non-emergency transportation).
QLD	Queensland residents receive free cover for authorised ambulance services throughout Australia under a QLD state government ambulance scheme. Cover applies anywhere in Australia. For more information visit ambulance.qld.gov.au

Key terms

The following are brief descriptions of the types of services covered by Extras. For more information about each product, service or treatment, contact the industry associations suggested. For information about what you're covered for, take a look at the detailed cover guides on pages 42-61 or call our member care team on 1300 806 808.

General dental

Includes treatments related to oral hygiene, scaling and cleaning, restorations (fillings), extractions, x-rays.

Major dental

Endodontics

More commonly known as 'root canal therapy', endodontics is the process of removing damaged tissue from inside a tooth, which can relieve pain and help avoid the need to remove a damaged tooth.

Crowns and bridges

Crowns are 'tooth caps' used to strengthen damaged teeth or improve their appearance. Bridges are designed to hold false teeth in place, and are made up of crowns attached to the natural teeth on either side of a false tooth or teeth.

Dentures

These are removable 'false teeth.' While they can replace all of your teeth if necessary, it's just as common to have dentures to replace just one, or a few, missing teeth.

Periodontics

Also known as gum disease, periodontitis can weaken the tissue that supports your teeth and cause them to fall out. The treatment for gum disease is a deep-cleaning procedure called 'periodontics.'

Orthodontics

Orthodontics corrects the growth and alignment of teeth, often through the use of braces or other appliances.

> For more information, visit the Australian Dental Association, ada.org.au

Optical

Lenses and contact lenses

Prescription lenses can be single, bifocal or multifocal, depending on your optical needs. Contact lenses do away with frames entirely by resting directly on the eye.

> For more information, visit the Optometrists Association Australia, optometrists.asn.au

Irlen lenses

Irlen Syndrome is a form of perceptual dyslexia, which is often caused by the brain misprocessing light and glare. Irlen lenses are specially tinted lenses, which can be used in conjunction with an optical prescription (if necessary) that correct this processing difficulty and improve perception.

> For more information, visit the Irlen Dyslexia Centre, dyslexiaservices.com.au

Therapies

Chiropractic

Chiropractic adjustment involves the manipulation of 'locked up' joints in the spine in order to help it regain normal movement and function, and can also help to restore the body's natural healing tendencies.

> For more information, visit the Chiropractors' Association of Australia, chiropractors.asn.au

Osteopathy

Osteopathy uses a variety of hands-on treatments, such as massage and stretching, to treat damaged muscles, tendons and ligaments. It is often used as part of a pain management regime and to help in increasing mobility in joints.

> For more information, visit the Australian Osteopathic Association, osteopathic.com.au

Physiotherapy

Physiotherapy provides treatment, advice and rehabilitation options for people suffering from movement or mobility disorders. It uses a variety of methods, such as massage, exercise programs, muscle re-education and movement aids (such as crutches or wheelchairs), to assist with pain management and provide improved quality of life.

> For more information, visit the Australian Physiotherapy Association, physiotherapy.asn.au

Podiatry

Podiatry aids in mobility and comfort by diagnosing and treating problems concerning the feet, including corns and calluses, nerve damage caused by diabetes, and rehabilitation after surgery.

> For more information, visit the Australasian Podiatry Council, apodc.com.au

Myotherapy

Myotherapy combines several types of massage, including soft tissue treatment, trigger point therapy, myofascial dry needling, thermal therapy and electrical stimulations with corrective exercises as part of a pain management regime. It can be used to assist with chronic musculoskeletal conditions, postural conditions, sporting and occupational injuries, and works by releasing toxins from the muscles and improving blood flow in the body.

> For more information, visit the Australian Institute of Myotherapists, myotherapy.org.au

Psychology

Psychologists provide assistance for people suffering from stress or anxiety, and some mental health disorders. While psychologists cannot prescribe medication, they assist patients by giving them techniques that will help them to alter their behaviour and emotional responses.

> For more information, visit the Australian Psychological Society, psychology.org.au

Acupuncture

Acupuncture is a well-recognised part of Chinese Medicine which involves the insertion of fine, sterilised needles into the body. Acupuncture can deliver drug-free pain relief, provide relief from a wide range of chronic conditions and assist in the maintenance of general wellbeing.

> For more information, visit the Australian Acupuncture and Chinese Medicine Association, acupuncture.org.au

Remedial massage
Remedial massage uses slow movements and deep finger pressure to relieve chronic muscular pain, help with rehabilitation after injury and assist with physical and mental fatigue.

> For more information, visit the Australian Association of Massage Therapists, aamt.com.au

Chinese herbalism
Comprised of acupuncture, herbal medicine, massage, breathing therapy and dietary advice, this is a traditional form of medicine that takes a holistic approach to a patient's health and wellbeing, and focuses as much on the prevention of illness as the treatment of it.

> For more information, visit the Australian Acupuncture and Chinese Medicine Association, acupuncture.org.au

Dietetics
Dietitians provide information, counselling and diet plans for people with specific nutritional requirements, including heart problems, high blood pressure, diabetes and eating disorders. They can also provide assistance for people with specific lifestyle needs, including women who wish to become pregnant, new mothers and athletes who want to improve performance.

> For more information, visit the DietiTians Association of Australia, daa.asn.au

Occupational therapy
Occupational therapy helps people with disabilities or other long-term medical conditions to regain quality of life by giving them techniques and skills that enable them to participate fully in daily life. It can also be of assistance in helping people to alter their environment to better accommodate their needs.

> For more information, visit Occupational Therapy Australia, ausot.com.au

Orthoptics
Orthoptics provides specialist testing and treatment of eye movement disorders and diseases, as well as rehabilitation and assistance for people suffering from vision loss.

> For more information, visit Orthoptics Australia, orthoptics.org.au

Speech therapy
Now known as speech pathology, speech therapy provides assessment and treatment for people living with communication disorders, including those associated with cleft palates, stuttering, strokes and intellectual disabilities. Speech pathologists use a variety of methods in both individual and classroom environments to assist people in improving their communication abilities.

> For more information, visit Speech Pathology Australia, speechpathologyaustralia.org.au

Health services

Home nursing
Home care providers can offer in-home clinical care, companionship and domestic and nutritional assistance for patients recovering outside the hospital environment, or people living with long-term illnesses or disabilities.

> For more information, visit Aged Care Online, agedcareonline.com.au

Health aids

Orthotics and orthopaedic shoes
Orthotics are external devices that are fitted to the shoe in order to provide support and alignment, promote mobility and reduce pain. Orthopaedic shoes are specially designed to fit and assist people with foot or leg conditions. Orthopaedics provide support and comfort to address foot abnormalities, including those caused by diabetes, bunions and hip replacement procedures.

> For more information, visit Orthopaedics Australia, orthopaedicsaustralia.com.au

Artificial eye
When an eye is lost to illness or injury, an artificial eye can be created to replace it. Artificial eyes are made by taking an impression of the eye socket and using it to create a realistic-looking prosthesis.

> For more information, visit the Ocularists Association of Australia, ocularistsaustralia.com

Artificial limb
Also called 'prostheses,' artificial limbs are specially designed and custom made for each individual. Prostheses are intended to replace the look and usage of a lost limb as much as possible, and can increase an amputee's mobility and confidence.

> For more information, visit the Australian Orthotic Prosthetic Association, aopa.org.au

Blood glucose monitor
These are portable devices that enable people living with diabetes to test the level of glucose in their blood, giving them more control over the management of their condition on a daily basis.

> For more information, visit Diabetes Australia, diabetesaustralia.com.au

Blood pressure monitor
A blood pressure monitor is a portable device that allows a person to track and monitor their blood pressure without needing to consult a health professional. They can be useful for monitoring changes in blood pressure but should not replace the attention and advice of a healthcare professional.

Braces and splints
Braces and splints can be generic or custom made, and are designed to provide support, warmth, joint stabilisation and compression for people recovering from injury or surgery.

BPAP and CPAP machines
BPAP and CPAP machines are breathing aids that use facemasks and oxygen to help people living with sleep apnoea to enjoy a good night's sleep.

> For more information, visit the National Institute of Neurological Disorders and Stroke, ninds.nih.gov

Compression garments
These are garments that provide support, warmth and promote circulation, and can be very useful for people suffering from injuries and recovering from surgery.

> For more information, visit the Australian Physiotherapy Association, physiotherapy.asn.au

External breast prostheses
Made from a variety of materials, including foam or silicone, external breast prostheses are designed to be used by women who have had all or part of a breast surgically removed, and can be of great benefit in increasing confidence and positive body image.

> For more information, visit Cancer Council Victoria, cancervic.org.au

Nebuliser
A nebuliser is a device, often used by asthma sufferers, that converts medication into a fine mist, which can then be easily inhaled through a mask or mouthpiece.

> For more information, visit the National Asthma Council Australia, nationalasthma.org.au

TENS machine
TENS stands for 'transcutaneous electrical nerve stimulation.' A TENS machine delivers a gentle electrical charge through electrodes taped to the skin, and is used to relieve pain.

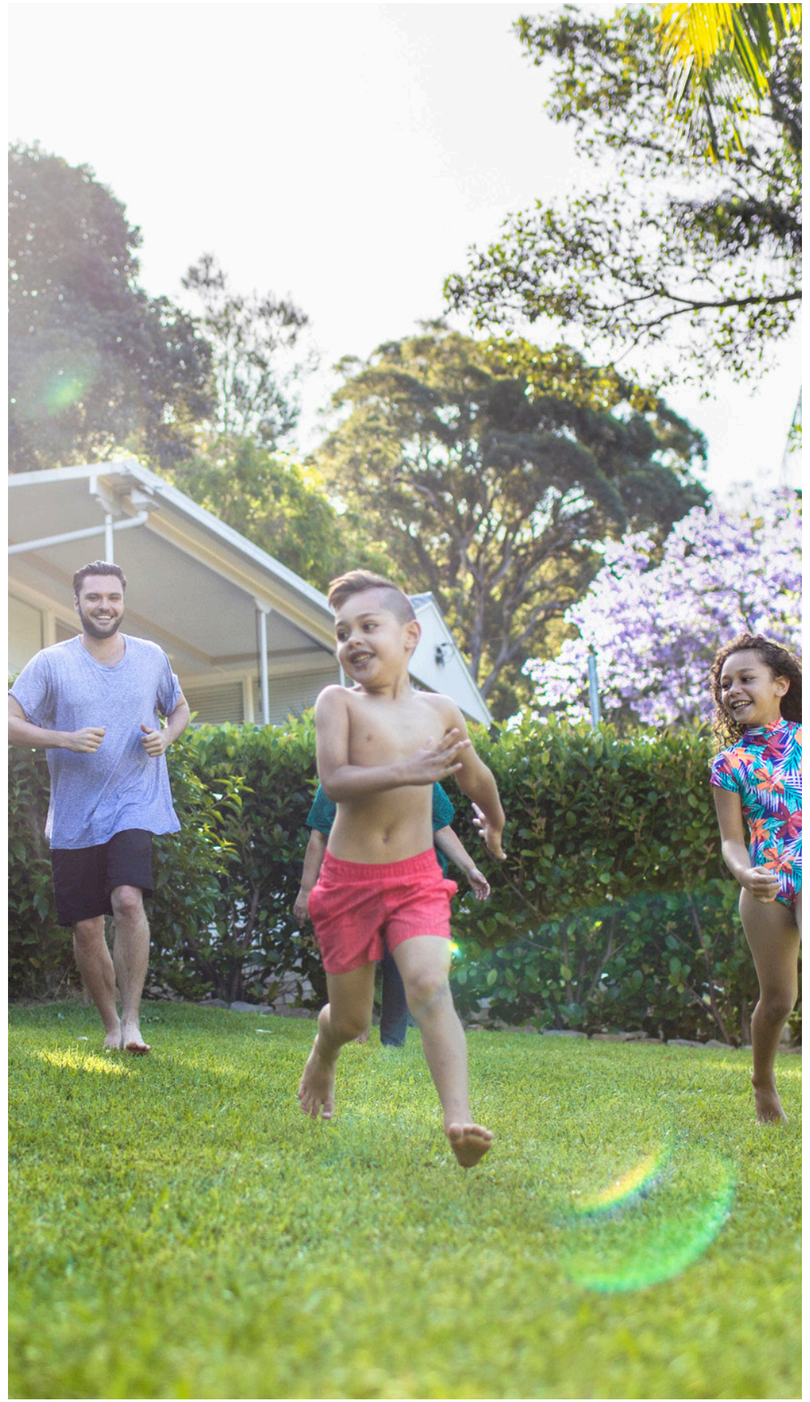
Wheelchairs
Wheelchairs are used by people for whom walking is difficult or impossible due to illness, injury or disability.

Low vision aids for ARMD
Including special lenses, magnifiers and electronic devices that can enlarge text or increase the contrast on an image, these aids assist people with a vision disability caused by age-related macular degeneration (ARMD).

> For more information, visit the Macular Degeneration Foundation, mdfoundation.com.au

Hearing aids
Consisting of a microphone, amplifier and earphone, these devices make it easier for people with hearing impairments to pick up sounds.

> For more information, visit Australian Hearing, hearing.com.au



Governing documents

Fund rules

Every transaction we do is governed by our fund rules and policies.

All Transport Health members are subject to the fund rules, which can change from time to time. A copy of the rules can be viewed on our website.

If a change to the rules will have a detrimental effect on your benefit entitlements, we will notify you in writing before the change comes into effect.

If the change is defined as a 'significant detrimental change' to your cover, you will receive notice in writing at least 60 days prior to it taking effect. If the change is defined as being detrimental but not significant, you will receive written notice at least 30 days prior to it taking effect.

A significant detrimental change to Hospital cover is any change that:

- removes or restricts material benefits for any condition
- adds a material excess/co-payment
- increases an existing excess/co-payment by more than 50%.

A significant detrimental change to extras cover is any change that:

- introduces a new limit or sub-limit
- reduces any benefit limit by more than 50%.

Detrimental changes will not apply to hospital admissions that are pre-booked at the time the change is communicated to members. Members will have the opportunity to speak with us about how the transitional arrangements will work in their individual situation if they are currently undergoing a treatment that will be affected.

The Private Health Insurance Code of Conduct

Transport Health is a signatory to the industry's voluntary code of conduct. The code is designed to help health fund members by ensuring that funds provide clear information and transparency. It covers four main areas:

1. Ensuring you receive the correct information from appropriately trained staff.
2. Ensuring you are aware of the internal and external dispute resolution procedures available in the event that you have a dispute with the fund.
3. Ensuring policy documentation contains all the information you require to make a fully informed decision about your purchase, and that all communications between you and the fund are conducted in such a way that the appropriate information flows between the parties. This includes staff, agents and brokers.
4. Ensuring that all information between you and the fund is protected in accordance with national and state privacy principles.

As a signatory to the code, we will:

- work toward improving our standards of practice and service
- provide information to you in plain language
- promote better informed decisions about our private health insurance products and services by:
  - ensuring that our policy documentation is full and complete
  - providing you with clear explanations of the contents of policy documentation when asked
  - ensuring that the people providing you with information on health insurance are appropriately trained.
- ensure information exchanged between you and us is protected in accordance with privacy principles
- provide information to you on your rights and obligations in your relationship with us, including information on this code of conduct
- provide you with easy access to our internal dispute resolution procedure, and advise you of your rights to take an issue to an external body such as the Commonwealth Ombudsman.

> If you're interested in reading more about the code of conduct, visit **privatehealthcareaustralia.org.au/codeofconduct**

Privacy policy

We are committed to handling all personal information we collect in accordance with the Privacy Act 1988 (Cth), and to making sure that the information we hold for members is handled in a responsible manner and that privacy is protected.

A full copy of our privacy policy is available on our website, and we will update it as required so you are always aware of the type of information we collect, how it may be used, and under what circumstances it may be disclosed by us.

> **If you are interested in reading our privacy policy, ask us for a printed copy or read it online at transporthealth.com.au**

In terms of how you interact with us, there are a few things we do to protect your privacy that you should be aware of:

Verification procedures – whenever you contact us by phone, we will ask you a few questions to establish your identity and make sure that we are talking to the principal member or a properly authorised partner or third party. Even if you're a regular caller, we must go through this quick verification process before we can start discussing your membership with you. If you are unable or unwilling to provide us with this information, we will not be able to assist you.

Principal member and partner authorities – if you have a couples or family membership, you would have been asked to nominate one person to be the 'principal member' at the time you joined (that is the person in whose name the membership is held). The principal member is the only person with an automatic entitlement to manage the membership – that includes signing claim forms, asking questions about claims, making changes to the membership and so on. The principal member can grant an authority to his or her spouse / partner if that person is named on the membership or to a third party who is not named on the membership. That authority can give the nominated person the ability to interact with us in the same way as the principal member can, with the exception of being able to suspend or cancel the membership – only the principal member can do that.

Without an appropriate authority in place, no other person covered by the membership is able to sign claim forms, make enquiries about the membership or make changes to the membership, and we will be unable to assist any other person with enquiries about the membership.

FIND OUT MORE ON PAGE 7.

Government programs and incentives

Lifetime Health Cover

Lifetime Health Cover (LHC) is a government program that was introduced in the year 2000. Its aim is to give people an incentive to take out private hospital cover before the age of 31 (and to maintain it throughout their lifetime) by enabling those people to pay lower contributions than people who take out Hospital cover for the first time after the age of 31, or who allow their cover to lapse for long periods.

Here's how it works:

- If you take out private hospital cover before the 1st of July following your 31st birthday (i.e. before the end of the financial year in which you turn 31), you'll pay the 'base rate' offered by the health fund you join.
- For every year you are over 31 when you join, you add 2% to the base rate contribution.
- The additional amount you have to pay above the base rate is called your 'Lifetime Health Cover loading.' As an example, if you take out private hospital cover for the first time when you are 40 you'll pay 20% more than someone who takes it out at 30 (2% x 10 years = 20% loading).
- The maximum loading that anyone ever has to pay is 70%, and that's if they take out private hospital cover for the first time when they are 65.
- Anyone born on or before 1 July 1934 can join Hospital cover at any time and only pay the base rate, the same as someone who joins when they are 30.

- From 1 July 2013, the government stopped paying any rebate on the Lifetime Health Cover loading. If you have a loading, you will be responsible for paying the full amount and any government rebate you are entitled to will only apply to the base rate contribution.

You can lock in your LHC Loading (or no loading) by maintaining your Hospital cover on a continuous basis. Dropping your cover may mean that when you join again, you are liable to pay a loading, even if you didn't have one when you previously held your cover.

You don't need to maintain your cover with the same health fund in order to avoid an LHC Loading. Provided you transfer between health funds without allowing your cover to lapse, it will be considered to be continuous.

Your Certified Age of Entry

The age at which you first take out private hospital cover is called your Certified Age of Entry (CAE). This is used to determine whether or not you will have to pay an LHC.

If you are under the age of 31 when you first take out Hospital cover, your CAE will be recorded as '30', whether or not you were actually 30 years old at the time you joined. All this number does is indicate to the various computer systems that need to talk to each other that you are not liable to pay an LHC Loading. If you are 31 or over when you first take out private hospital cover, your CAE will be recorded as your actual age at joining.

Permitted days without hospital cover

Under certain circumstances throughout your lifetime, the government allows you to be over the age of 31 and without private hospital cover for a total of 1,094 days (three years, less one day) without incurring an LHC Loading. These are called 'absent days' and they only start to kick in after you've reached the age at which a loading becomes applicable, and only if you hold private hospital cover at your LHC age deadline (that is, before the 1st of July following your 31st birthday). In other words, you can't use absent days to delay taking out private hospital cover for the first time after the age of 31. It's also important to note that, even though you may be protected from incurring a loading during your absent days, you may still need to serve waiting periods again when you next take out Hospital cover, and you may be liable to pay the Medicare Levy Surcharge. For more information on Permitted Days without cover visit Privatehealth.gov.au

10-year loading limit

The original Lifetime Health Cover program imposed a loading that people would pay for the rest of their lives. In 2007, a rule was announced that would enable people with an LHC Loading to have it removed after they've held Hospital cover continuously for 10 years. In 2010, the first people to have held their Hospital cover continuously since the year 2000 had their loading removed. If you have an LHC Loading and are able to demonstrate 10 continuous years of private hospital cover with one or a number of different funds, you will be eligible to have your loading removed.

> If you are interested in reading more about Lifetime Health Cover, take a look at the Commonwealth Ombudsman's Website PrivateHeath.gov.au

Medicare Levy Surcharge

Most of us pay a Medicare Levy through our income tax. It helps to fund the public health system. People who earn over a certain amount, and who don't have private hospital cover (Extras cover doesn't count in this instance), also have to pay an additional tax, which is called the Medicare Levy Surcharge. The amount of the surcharge increases on a sliding-scale basis as your income increases: the higher your income, the higher the amount of surcharge you will pay if you don't have private hospital cover.

The income threshold amounts are indexed at the start of each financial year. Find out what the current threshold is by visiting ato.gov.au and searching 'Medicare Levy Surcharge.'

To avoid paying the MLS, you must have private hospital cover and if you choose a cover with an excess, it must be no higher than $750 per year for a single cover, or $1,500 per year for a couples or family cover. All of our Hospital covers and excess options will exempt you from having to pay the MLS.

If you have dependent children, and your income is within the thresholds that would make you liable to pay the MLS, you cannot avoid it by taking out cover as a single; you must cover your dependent children as well.

> If you are interested in reading more, visit the Australian Taxation Office website, ato.gov.au

Once off waiting period exemption for hospital psychiatric services

See page 21 for details or visit:

www.health.gov.au/internet/main/publishing.nsf/Content/health-privatehealth-supporting-mental-health

Australian Government Rebate on Private Health Insurance

Depending on your age, income and the number of dependent children you have, the government will chip in a portion of the cost of your health cover.

Everyone who is a Medicare cardholder and a member of a registered private health fund in Australia may be eligible to receive the Australian Government Rebate on Private Health Insurance. It applies to Hospital, Extras and Ambulance.

The Australian Taxation Office sets a range of income tiers that will determine what 'base level' of rebate you're eligible to receive, and this increases for people in the over 65 and over 70 age groups. The income tiers are indexed annually at the start of each new financial year. The rebate is applied on a sliding-scale basis, with higher income earners entitled to a lower level of rebate.

Visit the Australian Taxation Office website for more information on the program and the current income tier thresholds, ato.gov.au

You can nominate the Australian Government Rebate on Private Health Insurance tier that applies to you at the time of joining, or at any time during your Transport Health membership. By nominating a Australian Government Rebate on Private Health Insurance tier, the amount of Australian Government Rebate on Private Health Insurance you are receiving will be reduced, and amount of your contribution payment will increase accordingly. You can nominate or change your tier in our online member centre at any time. Please note, however, if you pay your health cover contributions via a salary deduction with your employer, changes to your tier will need to be made by completing a form with us, so we can advise your employer of the change in the amount of your deduction.

There are two different ways that you can receive the rebate and you can choose whichever suits you best:

1. You can take the rebate as a reduction in your contribution rate. If you choose this option, we reduce the cost of your health cover by the amount of the Australian Government Rebate on Private Health Insurance you are entitled to, and you only ever have to pay the balance.
2. You can pay 100% of your contribution and claim your Australian Government Rebate on Private Health Insurance through your income tax return.

Deciding which way to receive your Australian Government Rebate on Private Health Insurance is probably something that is best discussed with your accountant, and you can change the way you receive it any time. We'll ask you for all the information we need to apply it to your membership when you join.

For more information on rebate tiers and entitlements, please visit ato.gov.au

Reciprocal healthcare agreements

When you travel overseas, you're not covered by your private health cover or Medicare. To provide limited assistance to Australian residents travelling abroad, the government has signed Reciprocal HealthCare Agreements with a number of countries. These agreements offer Australian residents assistance with the cost of medically-necessary treatment while travelling in:

- New Zealand
- United Kingdom
- Republic of Ireland
- Sweden
- The Netherlands
- Finland
- Italy
- Malta
- Norway
- Belgium
- Slovenia.

These agreements do not offer a substitute to travel insurance. Even if you are travelling to a Reciprocal Healthcare Agreement country, travel insurance with cover for medical treatment is essential.

> Find out more by visiting the Medicare Australia website, Medicareaustralia.gov.au

Regulatory bodies

Private health insurance in Australia is a well-regulated industry. Among the key groups that oversee the operations of health funds, and that exist to help consumers, are the Commonwealth Ombudsman, the Australian Prudential Regulation Authority (APRA) and the Australian Goverment Department of Health.

The Commonwealth Ombudsman

The Commonwealth Ombudsman is an independent government agency that:

- helps consumers deal with health insurance problems and enquiries
- provides advice to the health insurance industry, government and consumers, and
- publishes independent information about private health insurance and the performance of health funds.

Any member of a health fund is entitled to contact the Ombudsman about any private health insurance-related matter, whether it is about the health fund, an insurance broker, a hospital, a medical practitioner, a dentist or other practitioner.

You can contact the Ombudsman at:

Call: 1300 362 072

Email: phio.info@ombudsman.gov.au

Visit: ombudsman.gov.au

Post: GPO BOX 442 Canberra ACT 2601

Among the many consumer resources available from the Ombudsman are:

- the annual *State of the Health Funds Report* – comparing the performance and service delivery of all health funds
- individual health fund report cards
- annual reports and quarterly bulletins
- a variety of different brochures on topics such as:
  - choosing a health insurance policy
  - how and why waiting periods work, including pre-existing conditions
  - transferring from one health insurance product to another
  - managing doctors' bills and potential out-of-pocket costs
  - tips to avoid problems with your health insurance
  - what to do if you want to make a complaint
  - your rights and responsibilities as a private patient in hospital
  - the rules about Lifetime Health Cover loadings.

All of these materials are available at no cost on the Ombudsman website (ombudsman.gov.au).

In addition, the Ombudsman manages the consumer website. This site provides information that enables people to more easily compare health insurance products between health funds by providing information on every product from every health fund in a consistent format. It also provides a wealth of additional material on private health insurance in Australia.

> Visit the website for more information, privatehealth.gov.au

Australian Prudential Regulation Authority

The Australian Prudential Regulation Authority (APRA) is the regulator of the Australian financial services industry. It oversees banks, credit unions, building societies, general insurance and reinsurance companies, life insurance, private health insurance, friendly societies, and most of the superannuation industry. APRA is funded largely by the industries that it supervises. It was established on 1 July 1998.

APRA currently supervises institutions holding $4.9 trillion in assets for Australian depositors, policyholders and superannuation fund members.

> Visit the APRA website for a great range of useful consumer information and publications, apra.gov.au

The Australian Government Department of Health

Private health insurance policy is set down by the Department of Health. Its website has a wealth of information about the government's key health programs and services, and useful resources to help people make more informed decisions about their health and wellbeing.

> Take a look at health.gov.au and choose the 'For Consumers' tab.

What to do if you have a complaint

We are committed to providing you with the best possible service, but we realise there will be times when we make a mistake or when you might have reason to make a complaint.

If you do have cause to make a complaint, please be assured that we will take it very seriously and will do everything we can to come to a solution that works for everyone.

The following two steps outline our internal complaints resolution process:

1. Capturing and learning from your complaint

Every complaint we receive by phone, mail, email or in person is logged as an issue in our internal complaints register. This is reviewed on a weekly basis by our Operations Manager who liaises with the various departments to identify ways in which our internal processes or communications can be improved, so we prevent similar situations from happening in future.

If you have requested or require a response to your complaint, we will endeavour to have a response to your issue within three business days of you raising it. This way you will know how your issue is progressing and when we hope to have it resolved for you, particularly if it is complex and taking longer than usual.

2. Resolving your issue

There are a number of stages of escalation within the organisation. If we are unable to resolve your issue at the first point of contact, it will be referred to a more senior team member and or manager.

We will advise you at each point of the process that if you are not happy with the resolution proposed by Transport Health, you are entitled to contact the Private Health Insurance Ombudsman about your complaint.

The Ombudsman is an independent body formed to help resolve complaints and to provide advice and information to members of private health funds. You can contact the Ombudsman at:

Call: 1300 362 072

Email: phio.info@ombudsman.gov.au

Visit: ombudsman.gov.au

Post: GPO BOX 442 Canberra ACT 2601

For more about the role of the Ombudsman and the services it provides, refer to page 40.

Can we help?

If you have any questions, our team is here to help. Contact us on **1300 806 808** or email us at **enquiries@transporthealth.com.au**

GOLD TOP HOSPITAL

Here's what you're covered for:

Private or public hospital costs - contracted private hospitals or public hospitals

Accommodation	Up to 100% of the cost. Depending on availability, this may be either a private or a shared room.
Operating theatre / Intensive care / Coronary care	Up to 100% of the cost.

Doctors' costs

Doctor of your choice	100% of the Medicare Benefits Schedule (MBS) fee for services provided by doctors in hospital. When you are treated in hospital, Medicare will pay 75% of the MBS fee for each 'item' and private hospital cover is only allowed by law to pay the remaining 25%. Doctors are not limited to only charging the MBS fee – and that's where people can end up with out-of-pocket costs, because the law prevents funds from paying more than 25% of the MBS fee. We offer a program as part of Gold Top Hospital that can help to reduce the likelihood of out-of-pocket costs. With Medicover, you can ask the doctors to charge a set fee based on a different fee schedule, which is higher than the MBS fee but probably not as much as they might otherwise charge. If they agree to Medicover, you will either have no out-of-pocket costs or you will know in advance what the costs will be. Please note that doctors usually work in a select few hospitals, which may limit the choice of hospitals available to you if you wish to be treated by a particular doctor.

Prostheses and pharmaceutical costs

Prostheses	100% of the cost of government approved no-gap prosthesis (lower benefits apply for other prosthesis provided that the prosthesis is not related to any of the items listed under exclusions). We recommend that you contact our member care team to find out exactly what you are covered for before going into hospital.
Pharmaceuticals	100% of the cost of: • TGA and PBS listed pharmacy items directly related to the reason for your hospitalisation, supplied to you during your admission provided they are not listed as a restricted drug. • pharmaceuticals listed on the Commonwealth Exceptional Drug List.

Ambulance attendance and transportation costs

Ambulance	Benefits for ambulance are paid when the service is provided by a state government operated, authorised or approved ambulance scheme. Residents of VIC, SA, WA, TAS, NT– unlimited cover for emergency ambulance transportation in the case of accident or illness. Cover applies anywhere in Australia. Residents of Tasmania are covered by a reciprocal state government ambulance scheme in all states except QLD and SA, so our Ambulance cover only applies where the state government scheme does not. You can also purchase additional Ambulance cover through a state government ambulance service. Residents of NSW or the ACT – unlimited cover for emergency transportation, and medically necessary non-emergency transportation. Cover applies anywhere in Australia. Please contact the fund prior to using any non-emergency patient transportation supplied by a hospital for inter-hospital transfers. Residents of QLD – unlimited cover under a QLD state government ambulance scheme for emergency transportation, and medically necessary non-emergency transportation. Cover applies anywhere in Australia. Contact the QLD state government ambulance provider for more information. *Your level of ambulance cover is based on the state the policy is held in. If you live in a different state to the residential address of the policy please contact our team.

Additional benefits

Hospital at Home (hospital substitution program)	Offers an alternative to a hospital admission or enables you to leave hospital early and receive treatment in your own home.	For more information, enrolment and referral forms, call our member care team on: **1300 806 808** or visit **transporthealth.com.au**
In Hospital Boarder Accommodation	$120 maximum benefit per calendar year.	
Travel and Accommodation	**Travel:** Benefit is up to $60 per round trip (over 200km). **Accommodation:** Benefit is up to $40 per night.	Please speak with our member care team on **1300 806 808** about when these benefits are payable.

GOLD TOP HOSPITAL

Here's where out-of-pocket costs can come from:

Treatments and procedures not covered by Medicare	If the treatment or procedure you're having cannot be claimed under Medicare, your normal cover entitlements won't apply. You will have substantial out-of-pocket costs.
Admission to a non-contracted private hospital	If you receive treatment or procedures in a private hospital that we do not have a contract with, we will pay a 'default benefit' towards your accommodation, but no other benefits for hospital costs are payable. You will have substantial out-of-pocket costs.
Hospital or medical costs for outpatient treatment	Your Top Hospital cover can only pay benefits for treatments you receive as an inpatient, that is, when you are admitted as a patient to hospital.
Private hospital emergency department fees	When you are treated in an emergency department, you are an outpatient (you have not yet been admitted to the hospital). No benefits are payable for outpatient treatment.
Pharmaceuticals	**Discharge pharmaceuticals** These are items prescribed for you to take home after you are discharged from hospital. No benefits are payable for these under your Top Hospital cover, but you may be able to claim under your Extras cover. **Other Pharmaceuticals** You are not covered for pharmaceuticals that are not TGA approved and listed on the Pharmaceutical benefit scheme.
Services such as television hire, internet access, purchase of newspapers, purchase of medication not related to the reason for your admission, hospital administration fees	Your Top Hospital cover does not pay benefits for these additional products or services.

Waiting periods:

Accidents	1 day	
General services	2 months	
Hospital psychiatric services, rehabilitation and palliative care	2 months	
Pre-existing conditions	12 months	A pre-existing condition is 'an ailment or illness, the signs or symptoms of which were in existence at any time during the six months preceding the day on which the member joined the fund or upgraded to a higher level of cover'. If you have a medical condition at the time you join Transport Health, or upgrade your existing Transport Health Hospital cover, you may not be immediately covered. If a claim looks like it may relate to a pre-existing condition, a medical advisor or practitioner appointed by us will examine the information provided by your doctor/s and any other material relevant to the claim, and will make a determination as to whether the condition is pre-existing or not.
Pregnancy and birth (obstetrics)	12 months	
Assisted reproductive services	2 months	Pre-existing rule conditions apply.

SILVER PLUS SELECT HOSPITAL

Here's what you're covered for:

Private or public hospital costs - contracted private hospitals or public hospitals

Accommodation	Up to 100% of the cost, after you've paid any excess or co-payment that may be applicable to your membership and provided that your treatment is not related to any items listed under 'restrictions'. Depending on availability, this may be either a private or a shared room.
Operating theatre / Intensive care / Coronary care	Up to 100% of the cost.

Doctors' costs

Doctor of your choice	100% of the Medicare Benefits Schedule (MBS) fee for services provided by doctors in hospital. When you are treated in hospital, Medicare will pay 75% of the MBS fee for each 'item' and private hospital cover is only allowed by law to pay the remaining 25%. Doctors are not limited to only charging the MBS fee – and that's where people can end up with out-of-pocket costs, because the law prevents funds from paying more than 25% of the MBS fee. We offer a program as part of Select Hospital that can help to reduce the likelihood of out-of-pocket costs. With Medicover, you can ask the doctors to charge a set fee based on a different fee schedule, which is higher than the MBS fee but probably not as much as they might otherwise charge. If they agree to Medicover, you will either have no out-of-pocket costs or you will know in advance what the costs will be. Please note that doctors usually work in a select few hospitals, which may limit the choice of hospitals available to you if you wish to be treated by a particular doctor.

Prostheses and pharmaceutical costs

Prostheses	100% of the cost of government approved no-gap prosthesis (lower benefits apply for other prosthesis provided that the prosthesis is not related to any of the items listed under exclusions). We recommend that you contact our member care team to find out exactly what you are covered for before going into hospital.
Pharmaceuticals	100% of the cost of: • TGA and PBS listed pharmacy items directly related to the reason for your hospitalisation, supplied to you during your admission provided they are not listed as a restricted drug. • pharmaceuticals listed on the Commonwealth Exceptional Drug List.

Ambulance attendance and transportation costs

Ambulance	Benefits for ambulance are paid when the service is provided by a state government operated, authorised or approved ambulance scheme. Residents of VIC, SA, WA, TAS, NT– unlimited cover for emergency ambulance transportation in the case of accident or illness. Cover applies anywhere in Australia. Residents of Tasmania are covered by a reciprocal state government ambulance scheme in all states except QLD and SA, so our Ambulance cover only applies where the state government scheme does not. You can also purchase additional Ambulance cover through a state government ambulance service. Residents of NSW or the ACT – unlimited cover for emergency transportation, and medically necessary non-emergency transportation. Cover applies anywhere in Australia. Please contact the fund prior to using any non-emergency patient transportation supplied by a hospital for inter-hospital transfers. Residents of QLD – unlimited cover under a QLD state government ambulance scheme for emergency transportation, and medically necessary non-emergency transportation. Cover applies anywhere in Australia. Contact the QLD state government ambulance provider for more information. *Your level of ambulance cover is based on the state the policy is held in. If you live in a different state to the residential address of the policy please contact our team.

Additional benefits

Hospital at Home (hospital substitution program)	Offers an alternative to a hospital admission or enables you to leave hospital early and receive treatment in your own home.	For more information, enrolment and referral forms, call our member care team on: **1300 806 808** or visit **transporthealth.com.au**
In Hospital Boarder Accommodation	$120 maximum benefit per calendar year.	
Travel and Accommodation	**Travel:** Benefit is up to $60 per round trip (over 200km). **Accommodation:** Benefit is up to $40 per night.	Please speak with our member care team on **1300 806 808** about when these benefits are payable.

SILVER PLUS SELECT HOSPITAL

Here's where out-of-pocket costs can come from:

Restrictions – things you are covered for as a private patient in a public hospital. In a private hospital, you will only receive minimum benefits and will incur significant out-of-pocket expenses.	Hospital psychiatric services
Treatments and procedures not covered by Medicare	If the treatment or procedure you're having cannot be claimed under Medicare, your normal cover entitlements won't apply. You will have substantial out-of-pocket costs.
Admission to a non-contracted private hospital	If you receive treatment or procedures in a private hospital that we do not have a contract with, we will pay a 'default benefit' towards your accommodation, but no other benefits for hospital costs are payable. You will have substantial out-of-pocket costs.
Hospital or medical costs for outpatient treatment	Your Select Hospital cover can only pay benefits for treatments you receive as an inpatient, that is, when you are admitted as a patient to hospital.
Private hospital emergency department fees	When you are treated in an emergency department, you are an outpatient (you have not yet been admitted to the hospital). No benefits are payable for outpatient treatment.
Pharmaceuticals	**Discharge pharmaceuticals** These are items prescribed for you to take home after you are discharged from hospital. No benefits are payable for these under your Select Hospital cover, but you may be able to claim under your extras cover. **Other Pharmaceuticals** You are not covered for pharmaceuticals that are not TGA approved and listed on the Pharmaceutical benefit scheme.
Services such as television hire, internet access, purchase of newspapers, purchase of medication not related to the reason for your admission, hospital administration fees	Your Select Hospital cover does not pay benefits for these additional products or services.

Waiting periods:

Accidents	1 day	
General services	2 months	
Hospital psychiatric services, rehabilitation and palliative care	2 months	Cover for hospital psychiatric services is restricted to public hospital under this cover. Waiting periods will apply should you choose to upgrade your cover so you are covered in a private hospital.
Pre-existing conditions	12 months	A pre-existing condition is 'an ailment or illness, the signs or symptoms of which were in existence at any time during the six months preceding the day on which the member joined the fund or upgraded to a higher level of cover'. If you have a medical condition at the time you join Transport Health, or upgrade your existing Transport Health Hospital cover, you may not be immediately covered. If a claim looks like it may relate to a pre-existing condition, a medical advisor or practitioner appointed by us will examine the information provided by your doctor/s and any other material relevant to the claim, and will make a determination as to whether the condition is pre-existing or not.
Pregnancy and birth (obstetrics)	12 months	
Assisted reproductive services	2 months	Pre-existing rule conditions apply.

SILVER PLUS SMART CHOICE HOSPITAL NO PREGNANCY

Here's what you're covered for:

Private or public hospital costs – contracted private hospitals and public hospitals	
Accommodation	Up to 100% of the cost, after you've paid the excess applicable to your membership and provided that your treatment is not related to any of the items listed under 'exclusions' or 'restrictions'. Depending on availability, this may be either a private or a shared room.
Operating theatre / Intensive care / Coronary care	Up to 100% of the cost, provided that your treatment is not related to any of the items listed under 'exclusions' or 'restrictions'.
Doctors' costs	
Doctor of your choice	100% of the Medicare Benefits Schedule (MBS) fee for services provided by doctors in hospital. When you are treated in hospital, Medicare will pay 75% of the MBS fee for each 'item' and private hospital cover is only allowed by law to pay the remaining 25%. Doctors are not limited to only charging the MBS fee – and that's where people can end up with out-of-pocket costs, because the law prevents funds from paying more than 25% of the MBS fee. We offer a program as part of all our hospital covers that can help to reduce the likelihood of out-of-pocket costs. With Medicover, you can ask your doctors to charge a set fee based on a different fee schedule, which is higher than the MBS fee but probably not as much as they might otherwise charge. If they agree to use Medicover, you will either have no out-of-pocket costs or you will know in advance what the costs will be. We can give you more information and assistance with this when you are planning your hospital stay. Please note that doctors usually work in a select few hospitals, which may limit the choice of hospitals available to you if you wish to be treated by a particular doctor.
Prostheses and pharmaceutical costs	
Prostheses	100% of the cost of government-approved no-gap prostheses (lower benefits apply for other prostheses), provided that the prostheses are not related to any of the items listed under 'exclusions'. We recommend that you contact our member care team to find out exactly what you're covered for before going into hospital.
Pharmaceuticals	100% of the cost of: • TGA and PBS listed pharmacy items directly related to the reason for your hospitalisation, supplied to you during your admission provided they are not listed as a restricted drug. • pharmaceuticals listed on the Commonwealth Exceptional Drug List.
Ambulance attendance and transportation costs	
Ambulance	Benefits for ambulance are paid when the service is provided by a state government operated, authorised or approved ambulance scheme. Residents of VIC, SA, WA, TAS, NT– up to $5,000 per person per year for emergency ambulance attendance or transportation in the case of accident or illness. Cover applies anywhere in Australia. Residents of Tasmania are covered by a reciprocal state government ambulance scheme in all states except QLD and SA, so our Ambulance cover only applies where the state government scheme does not. You can also purchase additional Ambulance cover through a state government ambulance service. Residents of NSW or the ACT – unlimited cover for emergency transportation, and medically necessary non-emergency transportation. Cover applies anywhere in Australia. Please contact the fund prior to using any non-emergency patient transportation supplied by a hospital for inter-hospital transfers. Residents of QLD – unlimited cover under a QLD state government ambulance scheme for emergency transportation, and medically necessary non-emergency transportation. Cover applies anywhere in Australia. Contact the QLD state government ambulance provider for more information. *Your level of ambulance cover is based on the state the policy is held in. If you live in a different state to the residential address of the policy please contact our team.
Additional benefits		
Hospital at Home (hospital substitution program)	Offers an alternative to a hospital admission or enables you to leave hospital early and receive treatment in your own home.	For more information, enrolment and referral forms, call our member care team on **1300 806 808** or visit **transporthealth.com.au**
Travel and Accommodation	**Travel:** Benefit is up to $60 per round trip (over 200km). **Accommodation:** Benefit is up to $40 per night.	Please speak with our member care team on **1300 806 808** about when these benefits are payable.

SILVER PLUS SMART CHOICE HOSPITAL NO PREGNANCY

Here's where out-of-pocket costs can come from:

Exclusions – things you are not covered for	• Pregnancy and birth (obstetrics) • Assisted reproductive services • Weight loss surgery
Restrictions – things you are covered for as a private patient in a public hospital. In a private hospital you will only receive minimum benefits and will incur significant out-of-pocket expenses.	• Hospital psychiatric services
Treatments and procedures not covered by Medicare	If the treatment or procedure you're having cannot be claimed under Medicare, your normal cover entitlements won't apply. You will have substantial out-of-pocket costs.
Admission to a non-contracted private hospital	If you receive treatment in a private hospital that we do not have a contract with, we will pay a 'default benefit' towards your accommodation, but no other benefits for hospital costs are payable. You will have substantial out-of-pocket costs.
Hospital or medical costs for outpatient treatment	Your Smart Choice Hospital No Pregnancy cover can only pay benefits for treatments you receive as an inpatient, that is, when you are admitted as a patient to hospital.
Private hospital emergency department fees	When you are treated in an emergency department, you are an outpatient (you have not yet been admitted to the hospital). No benefits are payable for outpatient treatment.
Pharmaceuticals	**Discharge pharmaceuticals** These are items prescribed for you to take home after you are discharged from hospital. No benefits are payable for these under your Smart Choice Hospital No Pregnancy cover, but you may be able to claim under your Extras cover. **Other Pharmaceuticals** You are not covered for pharmaceuticals that are not TGA approved and listed on the Pharmaceutical benefit scheme.
Services such as television hire, internet access, purchase of newspapers, purchase of medication not related to the reason for your admission, hospital administration fees	Your Smart Choice Hospital No Pregnancy cover does not pay benefits for these additional products or services.

Waiting periods:

Accidents	1 day	
General services	2 months	
Hospital psychiatric services, rehabilitation and palliative care	2 months	Cover for psychiatric services is restricted to public hospital under this level of cover. If you wish to be covered for psychiatric treatment in a private hospital, please contact our member care team. Waiting periods will apply if you choose to upgrade your cover.
Pre-existing conditions	12 months	A pre-existing condition is 'an ailment or illness, the signs or symptoms of which were in existence at any time during the six months preceding the day on which the member joined the fund or upgraded to a higher level of cover'. If you have a medical condition at the time you join Transport Health, or upgrade your existing Transport Health Hospital cover, you may not be immediately covered. If a claim looks like it may relate to a pre-existing condition, a medical advisor or practitioner appointed by us will examine the information provided by your doctor/s and any other material relevant to the claim, and will make a determination as to whether the condition is pre-existing or not.
Pregnancy and birth (obstetrics)	12 months	Not covered under this level of cover. Waiting periods will apply should you choose to upgrade for this service.
Assisted reproductive services	2 months	Pre-existing rule conditions apply. Not covered under this level of cover. Waiting periods will apply should you choose to upgrade for this service.

BRONZE PLUS FIRST CHOICE HOSPITAL

Here's what you're covered for:

Private or public hospital costs – contracted private hospitals and public hospitals		
Accommodation	Up to 100% of the cost, after you've paid the excess applicable to your membership and provided that your treatment is not related to any of the items listed under 'exclusions' or 'restrictions'. Depending on availability, this may be either a private or a shared room.	
Operating theatre / Intensive care	Up to 100% of the cost, provided that your treatment is not related to any of the items listed under 'exclusions' or 'restrictions'.	
Doctors' costs		
Doctor of your choice	100% of the Medicare Benefi ts Schedule (MBS) fee for services provided by doctors in hospital. When you are treated in hospital, Medicare will pay 75% of the MBS fee for each 'item' and private hospital cover is only allowed by law to pay the remaining 25%. Doctors are not limited to only charging the MBS fee – and that's where people can end up with out-of-pocket costs, because the law prevents funds from paying more than 25% of the MBS fee. We offer a program as part of our First Choice Hospital cover that can help to reduce the likelihood of out-of-pocket costs. With Medicover, you can ask your doctors to charge a set fee based on a different fee schedule, which is higher than the MBS fee but probably not as much as they might otherwise charge. If they agree to use Medicover, you will either have no out-of-pocket costs or you will know in advance what the costs will be. We can give you more information and assistance with this when you are planning your hospital stay. Please note that doctors usually work in a select few hospitals, which may limit the choice of hospital available to you if you wish to be treated by a particular doctor.	
Prostheses and pharmaceutical costs		
Prostheses	100% of the cost of government-approved no-gap prostheses (lower benefits apply for other prostheses), provided that the prostheses are not related to any of the items listed under 'exclusions'. We recommend that you contact our member care team to find out exactly what you're covered for before going into hospital.	
Pharmaceuticals	100% of the cost of: • TGA and PBS listed pharmacy items directly related to the reason for your hospitalisation, supplied to you during your admission provided they are not listed as a restricted drug. • pharmaceuticals listed on the Commonwealth Exceptional Drug List.	
Ambulance attendance and transportation costs		
Ambulance	Benefits for ambulance are paid when the service is provided by a state government operated, authorised or approved ambulance scheme. Residents of VIC, SA, WA, TAS, NT– up to $5,000 per person per year for emergency ambulance attendance or transportation in the case of accident or illness. Limits apply from 1 May 2020. Cover applies anywhere in Australia. Residents of Tasmania are covered by a reciprocal state government ambulance scheme in all states except QLD and SA, so our Ambulance cover only applies where the state government scheme does not. You can also purchase additional Ambulance cover through a state government ambulance service. Residents of NSW or the ACT – unlimited cover for emergency transportation, and medically necessary non-emergency transportation. Cover applies anywhere in Australia. Please contact the fund prior to using any non-emergency patient transportation supplied by a hospital for inter-hospital transfers. Residents of QLD – unlimited cover under a QLD state government ambulance scheme for emergency transportation, and medically necessary non-emergency transportation. Cover applies anywhere in Australia. Contact the QLD state government ambulance provider for more information. *Your level of ambulance cover is based on the state the policy is held in. if you live in a different state to the residential address of the policy please contact our team.	
Additional benefits		
Hospital at Home (hospital substitution program)	Offers an alternative to a hospital admission or enables you to leave hospital early and receive treatment in your own home.	For more information, enrolment and referral forms, call our member care team on **1300 806 808** or visit **transporthealth.com.au**
Travel and Accommodation	**Travel:** Benefit is up to $60 per round trip (over 200km). **Accommodation:** Benefit is up to $40 per night.	Please speak with our member care team on **1300 806 808** about when these benefits are payable.

BRONZE PLUS FIRST CHOICE HOSPITAL

Here's where out-of-pocket costs can come from:

Exclusions – things you are not covered for	• Heart and vascular system • Plastic and reconstructive surgery (medically necessary) • Joint replacements • Pregnancy and birth (obstetrics) • Weight loss surgery. • Back, neck and spine • Cataracts • Dialysis for chronic kidney failure • Assisted reproductive services
Restrictions – things you are covered for as a private patient in a public hospital. In a private hospital you will only receive minimum benefits and will incur significant out-of-pockets expenses.	• Rehabilitation • Hospital psychiatric services.
Treatments and procedures not covered by Medicare	If the treatment or procedure you're having cannot be claimed under Medicare, your normal cover entitlements won't apply. You will have substantial out-of-pocket costs.
Admission to a non-contracted private hospital	If you receive treatment in a private hospital that we do not have a contract with, we will pay a 'default benefit' towards your accommodation, but no other benefits for hospital costs are payable. You will have substantial out-of-pocket costs.
Hospital or medical costs for outpatient treatment	Your First Choice Hospital cover can only pay benefits for treatments you receive as an inpatient, that is, when you are admitted as a patient to hospital.
Private hospital emergency department fees	When you are treated in an emergency department, you are an outpatient (you have not yet been admitted to the hospital). No benefits are payable for outpatient treatment.
Pharmaceuticals	**Discharge pharmaceuticals** These are items prescribed for you to take home after you are discharged from hospital. No benefits are payable for these under your First Choice Hospital cover, but you may be able to claim under your Extras cover. **Other Pharmaceuticals** You are not covered for pharmaceuticals that are not TGA approved and listed on the Pharmaceutical benefit scheme.
Services such as television hire, internet access, purchase of newspapers, purchase of medication not related to the reason for your admission, hospital administration fees	Your First Choice Hospital cover does not pay benefits for these additional products or services.

Waiting periods:

Accidents	1 day	
General services	2 months	
Hospital psychiatric services, rehabilitation and palliative care	2 months	Cover for psychiatric and rehabilitation treatment is restricted to public hospital under this level of cover. If you wish to be covered for psychiatric and rehabilitation treatment in a private hospital, please contact our member care team. Waiting periods will apply if you choose to upgrade your cover.
Pre-existing conditions	12 months	A pre-existing condition is 'an ailment or illness, the signs or symptoms of which were in existence at any time during the six months preceding the day on which the member joined the fund or upgraded to a higher level of cover'. If you have a medical condition at the time you join Transport Health, or upgrade your existing Transport Health Hospital cover, you may not be immediately covered. If a claim looks like it may relate to a pre-existing condition, a medical advisor or practitioner appointed by us will examine the information provided by your doctor/s and any other material relevant to the claim, and will make a determination as to whether the condition is pre-existing or not.
Pregnancy and birth (obstetrics)	12 months	Not covered under this level of cover. Waiting periods will apply should you choose to upgrade for this service.
Assisted reproductive services	2 months	Pre-existing rule conditions apply. Not covered under this level of cover. Waiting periods will apply should you choose to upgrade for this service.

BRONZE PLUS HEALTHY CHOICE HOSPITAL

Here's what you're covered for:

Private or public hospital costs - contracted private hospitals or public hospitals	
Accommodation	Up to 100% of the cost, after you've paid any excess or co-payment that may be applicable to your membership and provided that your treatment is not related to any of the items listed under 'exclusions' or 'restrictions'. Depending on availability, this may be either a private or shared room.
Operating theatre / Intensive care	Up to 100% of the cost provided the treatment is not related to any of the items listed under 'exclusions' or 'restrictions'.
Doctors' costs	
Doctor of your choice	100% of the Medicare Benefi ts Schedule (MBS) fee for services provided by doctors in hospital. When you are treated in hospital, Medicare will pay 75% of the MBS fee for each 'item' and private hospital cover is only allowed by law to pay the remaining 25%. Doctors are not limited to only charging the MBS fee – and that's where people can end up with out-of-pocket costs, because the law prevents funds from paying more than 25% of the MBS fee. We offer a program as part of Healthy Choice Hospital that can help to reduce the likelihood of out-of-pocket costs. With Medicover, you can ask the doctors to charge a set fee based on a different fee schedule, which is higher than the MBS fee but probably not as much as they might otherwise charge. If they agree to Medicover, you will either have no out-of-pocket costs or you will know in advance what the costs will be. Please note that doctors usually work in a select few hospitals, which may limit the choice of hospital available to you if you wish to be treated by a particular doctor.
Prostheses and pharmaceutical costs	
Prostheses	100% of the cost of government approved no-gap prosthesis (lower benefits apply for other prosthesis provided that the prosthesis is not related to any of the items listed under exclusions). We recommend that you contact our member care team to find out exactly what you are covered for before going into hospital.
Pharmaceuticals	100% of the cost of: • TGA and PBS listed pharmacy items directly related to the reason for your hospitalisation, supplied to you during your admission provided they are not listed as a restricted drug. • pharmaceuticals listed on the Commonwealth Exceptional Drug List.
Ambulance and transportation costs	
Ambulance	Benefits for ambulance are paid when the service is provided by a state government operated, authorised or approved ambulance scheme. Residents of VIC, SA, WA, TAS, NT– up to $5,000 per person per year for for emergency ambulance transportation in the case of accident or illness. Cover applies anywhere in Australia. Residents of Tasmania are covered by a reciprocal state government ambulance scheme in all states except QLD and SA, so our Ambulance cover only applies where the state government scheme does not. You can also purchase additional Ambulance cover through a state government ambulance service. Residents of NSW or the ACT – unlimited cover for emergency transportation, and medically necessary non-emergency transportation. Cover applies anywhere in Australia. Please contact the fund prior to using any non-emergency patient transportation supplied by a hospital for inter-hospital transfers. Residents of QLD – unlimited cover under a QLD state government ambulance scheme for emergency transportation, and medically necessary non-emergency transportation. Cover applies anywhere in Australia. Contact the QLD state government ambulance provider for more information. *Your level of ambulance cover is based on the state the policy is held in. if you live in a different state to the residential address of the policy please contact our team.
Additional benefits		
Hospital at Home (hospital substitution program)	Offers an alternative to a hospital admission or enables you to leave hospital early and receive treatment in your own home.	For more information, enrolment and referral forms, call our member care team on: **1300 806 808** or visit **transporthealth.com.au**
In Hospital Boarder Accommodation	$120 maximum benefit per calendar year.	
Travel and Accommodation	**Travel:** Benefit is up to $60 per round trip (over 200km). **Accommodation:** Benefit is up to $40 per night.	Please speak with our member care team on **1300 806 808** about when these benefits are payable.

BRONZE PLUS HEALTHY CHOICE HOSPITAL

Here's where out-of-pocket costs can come from:

Exclusions – things you are not covered for	• Heart and vascular system • Joint replacements • Pregnancy and birth (obstetrics) • Weight loss surgery. • Cataracts • Dialysis for chronic kidney failure • Assisted reproductive services
Restrictions – things you are covered for as a private patient in a public hospital. In a private hospital, you will only receive minimum benefits and will incur significant out-of-pocket expenses.	• Rehabilitation • Hospital psychiatric services.
Treatments and procedures not covered by Medicare	If the treatment or procedure you're having cannot be claimed under Medicare, your normal cover entitlements won't apply. You will have substantial out-of-pocket costs.
Admission to a non-contracted private hospital	If you receive treatment or procedures in a private hospital that we do not have a contract with, we will pay a 'default benefit' towards your accommodation, but no other benefits for hospital costs are payable. You will have substantial out-of-pocket costs.
Hospital or medical costs for outpatient treatment	Your Healthy Choice Hospital cover can only pay benefits for treatments you receive as an inpatient, that is, when you are admitted as a patient to hospital.
Private hospital emergency department fees	When you are treated in an emergency department, you are an outpatient (you have not yet been admitted to the hospital). No benefits are payable for outpatient treatment.
Pharmaceuticals	**Discharge pharmaceuticals** These are items prescribed for you to take home after you are discharged from hospital. No benefits are payable for these under your Healthy Choice Hospital cover, but you may be able to claim under your Extras cover. **Other Pharmaceuticals** You are not covered for pharmaceuticals that are not TGA approved and listed on the Pharmaceutical benefit scheme.
Services such as television hire, internet access, purchase of newspapers, purchase of medication not related to the reason for your admission, hospital administration fees	Your Healthy Choice Hospital cover does not pay benefits for these additional products or services.

Waiting periods:

Accidents	1 day	
General services	2 months	
Hospital psychiatric services, rehabilitation and palliative care	2 months	Cover for psychiatric and rehabilitation treatment are restricted to public hospital under this cover. Waiting periods will apply should you choose to upgrade your cover so you are covered in a private hospital.
Pre-existing conditions	12 months	A pre-existing condition is 'an ailment or illness, the signs or symptoms of which were in existence at any time during the six months preceding the day on which the member joined the fund or upgraded to a higher level of cover.' If you have a medical condition at the time you join Transport Health, or upgrade your existing Transport Health Hospital cover, you may not be immediately covered. If a claim looks like it may relate to a pre-existing condition, a medical advisor or practitioner appointed by us will examine the information provided by your doctor/s and any other material relevant to the claim, and will make a determination as to whether the condition is pre-existing or not.
Pregnancy and birth (obstetrics)	12 months	Not covered under this level of cover. Waiting periods will apply should you choose to upgrade for this service.
Assisted reproductive services	2 months	Pre-existing rule conditions apply. Not covered under this level of cover. Waiting periods will apply should you choose to upgrade for this service.

BASIC PLUS PUBLIC HOSPITAL COVER

Here's what you're covered for:

Public hospital costs	
Accommodation	Up to 100% of the cost of shared room accommodation in a public hospital. If you elect to have a private room, you will have out-of-pocket costs.
Operating theatre / Intensive care / Coronary care	Up to 100% of the cost in a public hospital only.
Doctors' costs	
Doctor of your choice	100% of the Medicare Benefits Schedule (MBS) fee for services provided by doctors in hospital. When you are treated in hospital, Medicare will pay 75% of the MBS fee for each 'item' and Hospital cover is only allowed by law to pay the remaining 25%. Doctors are not limited to only charging the MBS fee – and that's where people can end up with out-of-pocket costs, because the law prevents funds from paying more than 25% of the MBS fee. We offer a program as part of all our Hospital covers that can help to reduce the likelihood of out-of-pocket costs. With Medicover, you can ask your doctors to charge a set fee based on a different fee schedule, which is higher than the MBS fee but probably not as much as they might otherwise charge. If they agree to use Medicover, you will either have no out-of-pocket costs or you will know in advance what the costs will be. We can give you more information and assistance with this when you are planning your hospital stay. Please note that doctors usually work in a select few hospitals, which may limit the choice of hospitals available to you if you wish to be treated by a particular doctor.
Prostheses and pharmaceutical costs	
Prostheses	100% of the cost of government-approved no-gap prostheses (lower benefits apply for other prostheses). We recommend that you contact our member care team to find out exactly what you're covered for before going into hospital.
Pharmaceuticals	100% of the cost of: • TGA and PBS listed pharmacy items directly related to the reason for your hospitalisation, supplied to you during your admission provided they are not listed as a restricted drug. • pharmaceuticals listed on the Commonwealth Exceptional Drug List.
Ambulance attendance and transportation costs	
Ambulance	Benefits for ambulance are paid when the service is provided by a state government operated, authorised or approved ambulance scheme. Residents of VIC, SA, WA, TAS, NT– up to $5,000 per person per year for emergency ambulance attendance or transportation in the case of accident or illness. Cover applies anywhere in Australia. Residents of Tasmania are covered by a reciprocal state government ambulance scheme in all states except QLD and SA, so our Ambulance cover only applies where the state government scheme does not. You can also purchase additional Ambulance cover through a state government ambulance service. Residents of NSW or the ACT – unlimited cover for emergency transportation, and medically necessary non-emergency transportation. Cover applies anywhere in Australia. Please contact the fund prior to using any non-emergency patient transportation supplied by a hospital for inter-hospital transfers. Residents of QLD – unlimited cover under a QLD state government ambulance scheme for emergency transportation, and medically necessary non-emergency transportation. Cover applies anywhere in Australia. Contact the QLD state government ambulance provider for more information. *Your level of ambulance cover is based on the state the policy is held in. If you live in a different state to the residential address of the policy please contact our team.
Additional benefits available		
Hospital at Home (hospital substitution program)	Offers an alternative to a hospital admission or enables you to leave hospital early and receive treatment in your own home.	For more information, enrolment and referral forms, call our member care team on **1300 806 808 or visit transporthealth.com.au**
Travel and Accommodation	**Travel:** Benefit is up to $60 per round trip (over 200km). **Accommodation:** Benefit is up to $40 per night.	Please speak with our member care team on **1300 806 808** about when these benefits are payable

BASIC PLUS PUBLIC HOSPITAL

Here's where out-of-pocket costs can come from:

Admission to a private hospital	If you receive treatment in a private hospital, we will pay a 'default benefit' toward your accommodation, but no other benefits for hospital costs are payable. You will have substantial out-of-pocket costs.
Treatments and procedures not covered by Medicare	If the treatment or procedure you're having cannot be claimed under Medicare, your normal cover entitlements won't apply. You will have substantial out-of-pocket costs.
Hospital or medical costs for outpatient treatment	Your Public Hospital cover can only pay benefits for treatments you receive as an inpatient, that is, when you are admitted as a patient to hospital.
Private hospital emergency department fees	When you are treated in an emergency department, you are an outpatient (you have not yet been admitted to the hospital). No benefits are payable for outpatient treatment.
Pharmaceuticals	**Discharge pharmaceuticals** These are items prescribed for you to take home after you are discharged from hospital. No benefits are payable for these under your Public Hospital cover, but you may be able to claim under your Extras cover. **Other Pharmaceuticals** You are not covered for pharmaceuticals that are not TGA approved and listed on the Pharmaceutical benefit scheme.
Services such as television hire, internet access, purchase of newspapers, purchase of medication not related to the reason for your admission, hospital administration fees	Your Public Hospital cover does not pay benefits for these additional products or services.

Waiting periods:

Accidents	1 day	
General services	2 months	
Hospital psychiatric services, rehabilitation and palliative care	2 months	
Pre-existing conditions	12 months	A pre-existing condition is 'an ailment or illness, the signs or symptoms of which were in existence at any time during the six months preceding the day on which the member joined the fund or upgraded to a higher level of cover.' If you have a medical condition at the time you join Transport Health, or upgrade your existing Transport Health Hospital cover, you may not be immediately covered. If a claim looks like it may relate to a pre-existing condition, a medical advisor or practitioner appointed by us will examine the information provided by your doctor/s and any other material relevant to the claim, and will make a determination as to whether the condition is pre-existing or not.
Pregnancy and birth (obstetrics)	12 months	
Assisted reproductive services	2 months	Pre-existing rule conditions apply.

SILVER PLUS SMART CHOICE HOSPITAL

Here's what you're covered for:

Private or public hospital costs – contracted private hospitals and public hospitals	
Accommodation	Up to 100% of the cost, after you've paid the excess applicable to your membership and provided that your treatment is not related to any of the items listed under 'exclusions' or 'restrictions'. Depending on availability, this may be either a private or a shared room.
Operating theatre / Intensive care / Coronary care	Up to 100% of the cost, provided that your treatment is not related to any of the items listed under 'exclusions' or 'restrictions'.
Doctors' costs	
Doctor of your choice	100% of the Medicare Benefits Schedule (MBS) fee for services provided by doctors in hospital. When you are treated in hospital, Medicare will pay 75% of the MBS fee for each 'item' and private hospital cover is only allowed by law to pay the remaining 25%. Doctors are not limited to only charging the MBS fee – and that's where people can end up with out-of-pocket costs, because the law prevents funds from paying more than 25% of the MBS fee. We offer a program as part of all our hospital covers that can help to reduce the likelihood of out-of-pocket costs. With Medicover, you can ask your doctors to charge a set fee based on a different fee schedule, which is higher than the MBS fee but probably not as much as they might otherwise charge. If they agree to use Medicover, you will either have no out-of-pocket costs or you will know in advance what the costs will be. We can give you more information and assistance with this when you are planning your hospital stay. Please note that doctors usually work in a select few hospitals, which may limit the choice of hospitals available to you if you wish to be treated by a particular doctor.
Prostheses and pharmaceutical costs	
Prostheses	100% of the cost of government-approved no-gap prostheses (lower benefits apply for other prostheses), provided that the prostheses are not related to any of the items listed under 'exclusions'. We recommend that you contact our member care team to find out exactly what you're covered for before going into hospital.
Pharmaceuticals	100% of the cost of: • TGA and PBS listed pharmacy items directly related to the reason for your hospitalisation, supplied to you during your admission provided they are not listed as a restricted drug. • pharmaceuticals listed on the Commonwealth Exceptional Drug List.
Ambulance attendance and transportation costs	
Ambulance	Benefits for ambulance are paid when the service is provided by a state government operated, authorised or approved ambulance scheme. Residents of VIC, SA, WA, TAS, NT– up to $5,000 per person per year for emergency ambulance attendance or transportation in the case of accident or illness. Cover applies anywhere in Australia. Residents of Tasmania are covered by a reciprocal state government ambulance scheme in all states except QLD and SA, so our Ambulance cover only applies where the state government scheme does not. You can also purchase additional Ambulance cover through a state government ambulance service. Residents of NSW or the ACT – unlimited cover for emergency transportation, and medically necessary non-emergency transportation. Cover applies anywhere in Australia. Please contact the fund prior to using any non-emergency patient transportation supplied by a hospital for inter-hospital transfers. Residents of QLD – unlimited cover under a QLD state government ambulance scheme for emergency transportation, and medically necessary non-emergency transportation. Cover applies anywhere in Australia. Contact the QLD state government ambulance provider for more information. *Your level of ambulance cover is based on the state the policy is held in. If you live in a different state to the residential address of the policy please contact our team.
Additional benefits		
Hospital at Home (hospital substitution program)	Offers an alternative to a hospital admission or enables you to leave hospital early and receive treatment in your own home.	For more information, enrolment and referral forms, call our member care team on **1300 806 808** or visit **transporthealth.com.au**
Travel and Accommodation	**Travel:** Benefit is up to $60 per round trip (over 200km). **Accommodation:** Benefit is up to $40 per night.	Please speak with our member care team on **1300 806 808** about when these benefits are payable.

SILVER PLUS SMART CHOICE HOSPITAL

Here's where out-of-pocket costs can come from:

Exclusions – things you are not covered for	• Joint replacements • Dialysis for chronic kidney failure.
Restrictions – things you are covered for as a private patient in a public hospital. In a private hospital you will only receive minimum benefits and will incur significant out-of-pocket expenses.	• Hospital psychiatric services
Treatments and procedures not covered by Medicare	If the treatment or procedure you're having cannot be claimed under Medicare, your normal cover entitlements won't apply. You will have substantial out-of-pocket costs.
Admission to a non-contracted private hospital	If you receive treatment in a private hospital that we do not have a contract with, we will pay a 'default benefit' towards your accommodation, but no other benefits for hospital costs are payable. You will have substantial out-of-pocket costs.
Hospital or medical costs for outpatient treatment	Your Smart Choice Hospital cover can only pay benefits for treatments you receive as an inpatient, that is, when you are admitted as a patient to hospital.
Private hospital emergency department fees	When you are treated in an emergency department, you are an outpatient (you have not yet been admitted to the hospital). No benefits are payable for outpatient treatment.
Pharmaceuticals	**Discharge pharmaceuticals** These are items prescribed for you to take home after you are discharged from hospital. No benefits are payable for these under your Smart Choice Hospital cover, but you may be able to claim under your Extras cover. **Other Pharmaceuticals** You are not covered for pharmaceuticals that are not TGA approved and listed on the Pharmaceutical benefit scheme.
Services such as television hire, internet access, purchase of newspapers, purchase of medication not related to the reason for your admission, hospital administration fees	Your Smart Choice Hospital cover does not pay benefits for these additional products or services.

Waiting periods:

Accidents	1 day	
General services	2 months	
Hospital psychiatric services, rehabilitation and palliative care	2 months	Cover for psychiatric services is restricted to public hospital under this level of cover. If you wish to be covered for psychiatric treatment in a private hospital, please contact our member care team. Waiting periods will apply if you choose to upgrade your cover.
Pre-existing conditions	12 months	A pre-existing condition is 'an ailment or illness, the signs or symptoms of which were in existence at any time during the six months preceding the day on which the member joined the fund or upgraded to a higher level of cover'. If you have a medical condition at the time you join Transport Health, or upgrade your existing Transport Health Hospital cover, you may not be immediately covered. If a claim looks like it may relate to a pre-existing condition, a medical advisor or practitioner appointed by us will examine the information provided by your doctor/s and any other material relevant to the claim, and will make a determination as to whether the condition is pre-existing or not.
Obstetrics and other pregnancy-related services and treatments	12 months	

BRONZE PLUS YOUNG SINGLES/COUPLES HOSPITAL

Here's what you're covered for:

Private or public hospital costs – contracted private hospitals or public hospitals	
Accommodation	Up to 100% of the cost after you have paid the applicable excess for your membership and provided that your treatment is not related to any of the items listed under the exclusions or restrictions. Depending on availability, this may be either a private or shared room.
Operating theatre / Intensive care	Up to 100% of the cost provided the treatment is not related to any of the items listed under 'exclusions' or 'restrictions'.
Doctors' costs	
Doctor of your choice	100% of the Medicare Benefits Schedule (MBS) fee for services provided by doctors in hospital. When you are treated in hospital, Medicare will pay 75% of the MBS fee for each 'item' and private hospital cover is only allowed by law to pay the remaining 25%. Doctors are not limited to only charging the MBS fee – and that's where people can end up with out-of-pocket costs, because the law prevents funds from paying more than 25% of the MBS fee. We offer a program as part of Young Singles/Couples Hospital cover that can help to reduce the likelihood of out-of-pocket costs. With Medicover, you can ask the doctors to charge a set fee based on a different fee schedule, which is higher than the MBS fee but probably not as much as they might otherwise charge. If they agree to Medicover, you will either have no out-of-pocket costs or you will know in advance what the costs will be. Please be aware Medicover is not available on restricted services. Please note that doctors usually work in a select few hospitals, which may limit the choice of hospital available to you if you wish to be treated by a particular doctor.
Prostheses and pharmaceutical costs	
Prostheses	100% of the cost of government approved no-gap prosthesis (lower benefits apply for other prosthesis provided that the prosthesis is not related to any of the items listed under exclusions). We recommend that you contact our member care team to find out exactly what you are covered for before going into hospital.
Pharmaceuticals	100% of the cost of: • TGA and PBS listed pharmacy items directly related to the reason for your hospitalisation, supplied to you during your admission provided they are not listed as a restricted drug. • pharmaceuticals listed on the Commonwealth Exceptional Drug List.
Ambulance attendance and transportation costs	
Ambulance	Benefits for ambulance are paid when the service is provided by a state government operated, authorised or approved ambulance scheme. Residents of VIC, SA, WA, TAS, NT– unlimited cover for emergency ambulance transportation in the case of accident or illness. Cover applies anywhere in Australia. Residents of Tasmania are covered by a reciprocal state government ambulance scheme in all states except QLD and SA, so our Ambulance cover only applies where the state government scheme does not. You can also purchase additional Ambulance cover through a state government ambulance service. Residents of NSW or the ACT – unlimited cover for emergency transportation, and medically necessary non-emergency transportation. Cover applies anywhere in Australia. Please contact the fund prior to using any non-emergency patient transportation supplied by a hospital for inter-hospital transfers. Residents of QLD – unlimited cover under a QLD state government ambulance scheme for emergency transportation, and medically necessary non-emergency transportation. Cover applies anywhere in Australia. Contact the QLD state government ambulance provider for more information. *Your level of ambulance cover is based on the state the policy is held in. if you live in a different state to the residential address of the policy please contact our team.
Additional benefits		
Hospital at Home (hospital substitution program)	Offers an alternative to a hospital admission or enables you to leave hospital early and receive treatment in your own home.	For more information, enrolment and referral forms, call our member care team on: **1300 806 808** or visit **transporthealth.com.au**
Chronic disease prevention and management program	Helps people self-manage existing or potential chronic diseases (including asthma, diabetes, arthritis, heart disease and others).	
Travel and Accommodation	**Travel:** Benefit is up to $60 per round trip (over 200km). **Accommodation:** Benefit is up to $40 per night.	Please speak with our member care team on **1300 806 808** about when these benefits are payable.

BRONZE PLUS YOUNG SINGLES/COUPLES HOSPITAL

Here's where out-of-pocket costs can come from:

Exclusions – things you are not covered for	• Heart and vascular system • Cataracts • Dialysis for chronic kidney failure • Assisted reproductive services • Insulin pumps. • Back, neck and spine • Joint replacements • Pregnancy and birth (obstetrics) • Weight loss surgery
Restrictions – things you are covered for as a private patient in a public hospital. In a private hospital, you will only receive minimum benefits and will incur significant out-of-pocket expenses.	• Rehabilitation • Hospital psychiatric services • Palliative care.
Treatments and procedures not covered by Medicare	If the treatment or procedure you're having cannot be claimed under Medicare, your normal cover entitlements won't apply. You will have substantial out-of-pocket costs.
Admission to a non-contracted hospital	If you receive treatment or procedures in a private hospital that we do not have a contract with, we will pay a 'default benefit' towards your accommodation, but no other benefits for hospital costs are payable. You will have substantial out-of-pocket costs.
Hospital or medical costs for outpatient treatment	Your Young Singles/Couples Hospital Cover can only pay benefits for treatments you receive as an inpatient, that is, when you are admitted as a patient to hospital.
Private hospital emergency department fees	When you are treated in an emergency department, you are an outpatient (you have not yet been admitted to the hospital). No benefits are payable for outpatient treatment.
Pharmaceuticals	**Discharge pharmaceuticals** These are items prescribed for you to take home after you are discharged from hospital. No benefits are payable for these under your Young Singles/Couples Hospital cover. **Other Pharmaceuticals** You are not covered for pharmaceuticals that are not TGA approved and listed on the Pharmaceutical benefit scheme.
Services such as television hire, internet access, purchase of newspapers, purchase of medication not related to the reason for your admission, hospital administration fees	Your Young Singles/Couples Hospital Cover does not pay benefits for these additional products or services.

Waiting periods:

Accidents	1 day	
General services	2 months	
Hospital psychiatric services and rehabilitation, Palliative care	2 months	Cover for psychiatric, rehabilitation and palliative care are restricted to public hospital under this cover. Waiting periods will apply should you choose to upgrade your cover so you are covered in a private hospital.
Pre-existing conditions	12 months	A pre-existing condition is 'an ailment or illness, the signs or symptoms of which were in existence at any time during the six months preceding the day on which the member joined the fund or upgraded to a higher level of cover. If you have a medical condition at the time you join Transport Health or upgrade your existing Transport Health Hospital cover, you may not be immediately covered. If a claim looks like it may relate to a pre-existing condition, a medical advisor or practitioner appointed by us will examine the information provided by your doctor/s and any other material relevant to the claim, and will make a determination as to whether the condition is pre-existing or not.
Pregnancy and birth (obstetrics)	12 months	Not covered under this level of cover. Waiting periods will apply should you choose to upgrade for this service.
Assisted reproductive services	2 months	Pre-existing rule conditions apply. Not covered under this level of cover. Waiting periods will apply should you choose to upgrade for this service.

TOP EXTRAS COVER

Here's what you're covered for:

		Benefit for each purchase, service or treatment		Annual limit	Waiting period
General dental	Includes x-rays, surgical items, preventive dentistry, restorations (fillings), scaling and cleaning, extractions, mouthguard, fluoride application and more	60% of the fee charged		$800 per person	2 months
Major dental	Periodontics, endodontics, crowns and bridges and dentures*	60% of the fee charged		$800 per person 1-3 years $1,000 per person 3-5 years $1,200 per person 5 years+ **Dentures claimable every three calendar years*	12 months
Orthodontics	All orthodontic treatment *(treatment plan required)*	100 of the fee charged		$500 per person 1st year $850 per person 2-4 years $1,000 per person 5 years+ $2,500 lifetime limit	12 months
Optical	All prescription frames, lenses and contact lenses, including Irlen lenses and repairs	100% of the fee charged		$300 per person	6 months
Therapies Physiotherapy, myotherapy, chiropractic, osteopathy and podiatry	Initial consultation Subsequent consultation	$42 $32		$850 per person $1,700 per membership	2 months
Acupuncture, remedial massage, Chinese herbalism, speech therapy, eye therapy (orthoptics), occupational therapy and dietetics	Initial consultation Subsequent consultation	$37 $27		$600 per person $1,200 per membership	
Psychology	Initial consultation Subsequent consultation	$70 $50		$550 per person $800 per membership	
Pharmaceuticals	Up to	$50 per script	Per non-PBS prescription payable after you have paid the equivalent of the PBS patient copayment amount for each item. A letter from a medical practitioner is required for some claims.	$400 per person $800 per membership	
Home Surgical Nursing		$22 per visit	Itemised account required including provider details.	$400 per person $800 per membership	
Health Aids Orthotics	A letter from a medical practitioner is required with all 'Health aids' claims. No benefits are payable for consumables used in conjunction with any of these items.	80% of the cost		$200 per person	12 months
Artificial eye/limb, blood glucose monitor, blood pressure monitor, nebuliser kit, asthma pump, peak flow meters and compression garments (non-sports)		80% of the cost to a maximum of $200 per aid		$400 per person $800 per family	

TOP EXTRAS COVER

Health First Approved programs; MRI scans (where no Medicare benefit is payable), specialist skin testing, quit smoking programs, weight-loss and stress management programs (consultations only)		70% of the cost per program to a maximum of: $200 per person $400 per membership	$300 per person $600 per membership	2 months
Membership Fees (registered organisations e.g. Diabetes Australia)		$20 per person		
Laser Eye Correction Surgery			$300 per person 3-5 years $500 per person 5 years+ $500 lifetime limit	36 months
Hearing Aids	Claimable every 3 years	100% of the charge	$1,000 per person	24 months
Audiology	Initial consultation Subsequent consultation	$32 $22		2 months

HEALTHY CHOICE EXTRAS COVER

Here's what you're covered for:

		Benefit for each purchase, service or treatment		Annual limit	Waiting period
General dental	Includes x-rays, surgical items, preventive dentistry, restorations (fillings), scaling and cleaning, extractions, mouthguard, fluoride application and more	60% of the fee charged		$500 per person $1,000 per membership **Dentures claimable every three calendar years*	2 months
Major dental	Periodontics, endodontics, crowns and bridges and dentures*				12 months
Optical	All prescription frames, lenses and contact lenses, including Irlen lenses	100% of the fee charged		$225 per person	6 months
Specialist therapies Physiotherapy, myotherapy, chiropractic, osteopathy and podiatry	Initial consultation Subsequent consultation	$37 $27		$400 per person $800 per membership	2 months
Pharmaceuticals	Up to	$50 per script	Per non-PBS prescription payable after you have paid the equivalent of the PBS patient copayment amount for each item. A letter from a medical practitioner is required for some claims.	$400 per person $800 per membership	
Health First Approved programs; MRI scans (where no medicare benefit is payable), specialist skin testing, quit smoking programs, weight loss and stress management programs (consultations only)		70% of the cost per program to a maximum of: $200 per person $400 per membership		$300 per person $600 per membership	
Membership fees (registered organisations e.g. Diabetes Australia)		$20 per person			

YOUNG SINGLES/COUPLES EXTRAS COVER

Here's what you're covered for:

	Benefit for each purchase, service or treatment	Annual limit	Waiting period
Dental	70% of the fee charged	$300 per service type $600 per person $180 service limit applies to optical	2 months for general dental 12 months major dental
Optical			6 months
Physiotherapy			2 months
Chiropractic			
Remedial Massage			
Osteopathy			
Travel Vaccinations			

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